Within corporate limits

DR. ENFIELD

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

126

05600

Reg. Diat. No. 4

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: ALLEGANY
City or town: CUMBERLAND, MD.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred: MEMORIAL HOSPITAL
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: PENNA. County: BEDFORD
City or town: BUFFALO MILLS
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: MRS. SARAH ADAMS

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
FEMALE	WHITE	MARRIED

6.(b) Name of husband or wife: SAMUEL ADAMS

6.(c) If alive, give age: 52 years

7. Birth date of deceased (mo., day, yr.): MARCH 8, 1890

8. AGE: Years	Months	Days	If less than one day
57	4	23	hrs. min.

9. Birthplace: PENNA. (Town, county, and state)

10. Usual occupation: HOUSEWIFE

11. Industry or business

FATHER
12. Name: JOHN CORLEY
13. Birthplace: PENNA,

MOTHER
14. Maiden name: MARAH MOWERY
15. Birthplace: PENNA.

16. Informant: S. ADAMS
Address: BUFFALO MILLS, PA.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 8/3/47 (month) (day) (year)
Cemetery or crematory: Dry Ridge
Location: Mapes Church, PA
18. Funeral director: H. A. Ziegler
Address: Hyndman, Pa.

19. August 1, 1947 (Date rec'd by registrar) Winter L. Lantz, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: JULY 31, 1947 at 5:03 A.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from June 30, 19 47, to July 31, 19 47 and that I last saw her alive on July 30, 19 47

Immediate cause of death	DURATION
Pulmonary Abscess	
Due to Empyema	
Due to Obstruction	
Due to Stone Radium	
Other conditions	

(Include pregnancy within 3 months of death)

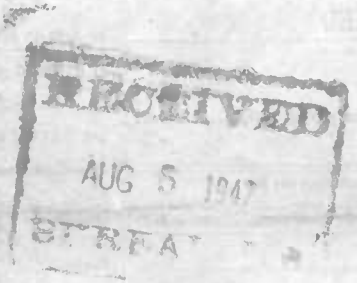
Major findings of operations: Date of op.

Autopsy results: as above Cause of death.

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: A. E. Rogers M. D. or other
Address: Cumberland Date signed 8/3/47


RECEIVED
AUG 5 1947

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

128

05601 4

Reg. Dist. No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:
County Allegany
City or town Cumberland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
Memorial Hospital
How long in hospital or institution? 62 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Allegany
City or town Cumberland
(If outside city or town limits, write RURAL and give nearest town)
Street No. 9 Mullen St.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Mrs. Nancy Alkire

3.(b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widowed

6.(b) Name of husband or wife Truman Alkire
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) October 8, 1873

8. AGE: Years	Months	Days	If less than one day.
73	8	27	..... hrs. ..... min.

9. Birthplace Slanesville, Hampshire, West Virginia
(Town, county, and state)

10. Usual occupation Housewife

11. Industry or business

FATHER 12. Name Kirk Bride Taylor
13. Birthplace Virginia

MOTHER 14. Maiden name Louise Rannels
15. Birthplace West Virginia

16. Informant William Moreland
Address Cold Stream, W. Va.

17. Burial Date thereof July 7, 1947
(Burial, cremation, or removal. Which?) (month) (day) (year)
Cemetery or crematory Mt. Union Cemetery
Location near Slanesville, W. Va.

18. Funeral director John J. Hafer
Address Cumberland, Md.

19. July 7, 1947 Winter R. Frantz, M.D. acting
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 5 1947, at 6:20 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 4, 1947, to July 5, 1947
and that I last saw her alive on July 4, 1947

	DURATION
Immediate cause of death	
Due to	
Due to Acute Pancreatitis	
Other conditions Generalized arteriosclerosis.	
(Include pregnancy within 3 months of death)	

Major findings of operations Gall bladder adhesions. Date of op.

Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE A. E. Rizzieddi M. D. or other
Address Date signed

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

61

Reg. Dist. No. 05602

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:

County: Allegany

City or town: Frostburg (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred: Memorial Hospital

How long in hospital or institution? 3 days

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: Md. County: Allegany

City or town: Frostburg (If outside city or town limits, write RURAL and give nearest town)

Street No. Arnold St (If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME Ella Arnold

3. (b) Social Security Number none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	married

6.(b) Name of husband or wife: George Arnold

6.(c) If alive, give age 56 years

7. Birth date of deceased (mo., day, yr.): May 13 — 1883

8. AGE: Years	Months	Days	If less than one day
64	2	0	hrs. min.

9. Birthplace: Garrett — Md (Town, county, and state)

10. Usual occupation: housewife

11. Industry or business

FATHER 12. Name: Samuel Meese

13. Birthplace: Md.

MOTHER 14. Maiden name: Kathern Beal

15. Birthplace: Md.

16. Informant: Charles Arnold

Address: Frostburg, Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof: July 15-47 (month) (day) (year)

Cemetery or ~~crematory~~: Greenville

Location: Greenville, Pa.

18. Funeral director: J. J. Durst

Address: Frostburg, Md

19. 7-15-47 (Date rec'd by registrar) Mrs. Nancy L. Roe Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 13 1947, at 1:30 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 1946 19.. to July 13 1947

and that I last saw h.. alive on July 12 1947

Immediate cause of death	DURATION
Chr. Myocarditis	4 mo
Due to	
Due to	
Other conditions: Diabetes	Several years

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: W. McLane Jr. M.D. M. D. or other

Address: Frostburg Md Date signed: July 14 1947

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 1860

CERTIFICATE OF DEATH

05603

S Reg. Dist. No. 4

1. PLACE OF DEATH:
County: Allegany
City or town: Cumberland Md.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? about 9 hours
Hospital, institution, or street address where death occurred:
Memorial Hospital
How long in hospital or institution? about 9 hours

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: W.Va. County: Tucker
City or town: Bluefield or Parsons
(If outside city or town limits, write RURAL and give nearest town)
Street No. 312 Princeton Ave.
(If rural, give LOCATION)
2.(a) If veteran, name war: no

3.(a) FULL NAME: Robert Eston Baughman

3.(b) Social Security Number: 233-10-7418

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	married

6.(b) Name of husband or wife: Katherine Burgess Baughman
6.(c) If alive, give age: 40 years

7. Birth date of deceased (mo., day, yr.): March 28, 1907

8. AGE: Years	Months	Days	If less than one day: hrs.	min.
40	3	7		

9. Birthplace: Parsons W.Va.
(Town, county, and state)
10. Usual occupation: photographer
11. Industry or business
FATHER 12. Name: Claude Baughman
13. Birthplace: St. George W.Va.
MOTHER 14. Maiden name: Sophia Fredrick
15. Birthplace: Pendleton Co. W.Va
16. Informant: Harry K Greenlief
Address: Parsons W.Va.
17. Burial (Burial, cremation, or removal. Which?) Date thereof: July 8 47 (month) (day) (year)
Cemetery or crematory: Parsons West Va.
Location: Parsons West Va.
18. Funeral director: Harry K Greenlief
Address: Parsons West Va.
19. July 7, 1947 (Date rec'd by registrar) Winter L. Frantz M.D. acting Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 5 1947, at 4.05 A.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..., to ..... 19.....
and that I last saw him alive Dead July 5 1947
Immediate cause of death: Epidural hemorrhage due to a fracture of the skull from a fall due to an epileptic **seizure. Right side of skull. — DURATION: about 10 hours
Due to: .....
Due to: Brain tumor, with hemorrhage left side of brain, cause of
Other conditions: ***** epileptic seizures. — DURATION: ?
(Include pregnancy within 3 months of death)
Major findings of operations: .....
Date of op. .....
Autopsy results: As above
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: accident Date of: 7-4-47
Where did injury occur? Cumberland (City or town) Allegany (County) Md. (State)
Injured at home, farm, industry, public place (where?): Allegany Co. Jail
Means of injury: Fell backward, struck head on concrete floor. Epileptic seizure (Injured at work?)
Deputy Medical Examiner - Allegany Co.
23. SIGNATURE: H.V.Deming M.D. H.V. Deming M.D. M. D. or Coroner
Address: Cumberland, Md. Date signed: 7-5-47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

Within corporate limits: Dr Ellison

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 70

CERTIFICATE OF DEATH

B 05604

Reg. Dist. No. 4

1. PLACE OF DEATH:

County ALLEGANY

City or town CUMBERLAND
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:
MEMORIAL HOSPITAL

How long in hospital or institution? 11 HRS 55 MINUTES

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State W. VA County MINERAL

City or town RIDGELEY
(If outside city or town limits, write RURAL and give nearest town)

Street No. 15 PERRY ST
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

JOHN BEAN JR

3. (b) Social Security Number

None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
MALE	WHITE	SINGLE

6.(b) Name of husband or wife

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) May 26, 1947

8. AGE: Years	Months	Days	If less than one day
~~7 WEEKS~~	1	18	..... hrs. ..... min.

9. Birthplace MARYLAND
(Town, county, and state)

10. Usual occupation

11. Industry or business

FATHER 12. Name JOHN BEAN, SR

FATHER 13. Birthplace MARYLAND

MOTHER 14. Maiden name MARIAN DUEL

MOTHER 15. Birthplace W.VA

16. Informant Mr. John Bean

Address 14 Walnut St. Ridgeley, W. Va.

17. Burial Date thereof July 16, 1947
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory HillCrest Cem.

Location Cumberland, Md,

18. Funeral director Charles L. George

Address Cumberland, Md.

19. July 16, 1947 Winter R. Trantz M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH JULY 14 19 47 at 7:45 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 7 19 47 to July 14 19 47 and that I last saw [illegible] alive on July 14 19 47

Immediate cause of death	DURATION
Rickets	6 wks
Due to Nutritional deficiency	
Due to	
Other conditions Cerebral Edema, Generalized Edema	

(Include pregnancy within 3 months of death)

Major findings of operation

Date of op

Autopsy results Mesenteric adenitis, Cerebral Edema,

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Dr. W. Ellison M.D.
M. D. or other

Address Cumberland Md Date signed 7-14-47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly

VS A15 9-45-15M


RECEIVED
JUL 22 1947

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

117 B

Reg. Dist. No. 05605 4

1. PLACE OF DEATH:

County: Allegany

City or town: Cumberland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Life

Hospital, Institution, or street address where death occurred: Allegany Hospital

How long in hospital or institution? 5 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Allegany

City or town: Cumberland

(If outside city or town limits, write RURAL and give nearest town)

Street No. 322 N. Mechanic St.

(If rural, give LOCATION)

2.(a) If veteran, name war: WW 2

3.(a) FULL NAME: COYLE EMORY BENNETT

3.(b) Social Security Number: 173-14-4826

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Velma (Schooley) Bennett

6.(c) If alive, give age: 31 years

7. Birth date of deceased (mo., day, yr.): December 11, 1914

8. AGE: Years	Months	Days	If less than one day
32	7	3	..... hrs. ..... min.

9. Birthplace: Oldtown, Allegany, Maryland (Town, county, and state)

10. Usual occupation: Tire Builder

11. Industry or business: Kelly Tire Company

FATHER — 12. Name: Vernon Bennett

FATHER — 13. Birthplace: Clearville, Pa.

MOTHER — 14. Maiden name: Nellie Bly Cunrod

MOTHER — 15. Birthplace: Piney Creek, Pa.

16. Informant: Mrs. Velma Bennett

Address: 322 N. Mechanic St. Cumberland, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 7/17/47 (month) (day) (year)

Cemetery or crematory: Everett Cemetery

Location: Everett, Pa.

18. Funeral director: H. Lee Silcox

Address: Cumberland, Md.

19. July 16, 1947 (Date rec'd by registrar) Walter R. Trautz M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 14 1947 at 4:10 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 8 1947 to July 14 1947 and that I last saw h... alive on July 13 1947

Immediate cause of death: Bleeding Duodenal Ulcer — DURATION: 1 week.

Due to: —

Due to:

Other conditions:

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: B. M. Schneider M.D. M. D. or other

Address: 41 Green St Date signed: July 14, 1947

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

932

05606

CERTIFICATE OF DEATH

Reg. Dist. No. 4

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:

County: Allegany

City or town: Cumberland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 35 years

Hospital, institution, or street address where death occurred:

330 Bedford Street

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Allegany

City or town: Cumberland

(If outside city or town limits, write RURAL and give nearest town)

Street No.: 330 Bedford Street

(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: EMMA E. BLUME

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband or wife: Elmer Blume

6.(c) If alive, give age: 79 years

7. Birth date of deceased (mo., day, yr.): May 4, 1869

8. AGE: Years	Months	Days	If less than one day
78	2	18	..... hrs. ..... min.

9. Birthplace: Bedford, Bedford County, Pa.
(Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business

FATHER 12. Name: Simon Naus

13. Birthplace: Pennsylvania

MOTHER 14. Maiden name: Loretta Milburn

15. Birthplace: Pennsylvania

16. Informant: Elmer Blume

Address: 330 Bedford Street, Cumberland, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: 7/25/47 (month) (day) (year)

Cemetery or crematory: Bedford Cemetery

Location: Bedford, Pa.

18. Funeral director: William H. Kight

Address: Cumberland, Md.

19. July 23, 1947 (Date rec'd by registrar) Winter R. Frantz, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 22, 1947, at 3:45 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 7/1/47, 19..., to 7/22/47, 19...; and that I last saw h[illegible] alive on 7/22/47, 19...

Immediate cause of death	DURATION
chronic myocarditis	
Due to: Hypertension	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results: .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: John N. Rogers M.D. M. D. or other

Address: Cumberland Md. Date signed: 7/22/47


RECEIVED
JUL 29 1947
BUBRAD U.S.

Within corporate limits

DR. HODGES

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

160a

05607

CERTIFICATE OF DEATH

S Reg. Dist. No. 4

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:
County ALLEGANY
City or town CUMBERLAND
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
MEMORIAL HOSPITAL
How long in hospital or institution? 1 DAY

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State WEST VIRGINIA County Grant
City or town PETERSBURG, W. VA.
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME BABY GIRL BORROR Gail Marie

3.(b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
FEMALE	WHITE	

6.(b) Name of husband or wife
6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) JULY 17, 1947

8. AGE: Years	Months	Days	If less than one day
			23 hrs. 15 min.

9. Birthplace CUMBERLAND, MARYLAND
(Town, county, and state)

10. Usual occupation

11. Industry or business

FATHER
12. Name RICHARD BORROR
13. Birthplace WEST VIRGINIA

MOTHER
14. Maiden name HELEN HARBY
15. Birthplace WEST VIRGINIA

16. Informant MEMORIAL HOSPITAL
Address CUMBE LAND, MD

17. Burial (Burial, cremation, or removal. Which?) Date thereof July 19, 1947 (month) (day) (year)
Cemetery or crematory Newhouse Cemetery
Location Rigg, W. Va.

18. Funeral director Charles L. George
Address Cumberland, Md.

19. July 18 47 (Date rec'd by registrar) Walter R. Frantz M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH JULY 18, 1 19 47 at 6:15 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 17 19 47 to July 17 19 47 and that I last saw h[illegible] alive on July 18 19 47

Immediate cause of death Fetus - Cranial Hemmorrhage — DURATION 1 Day

Due to Breech Delivery.

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations — Date of op.

Autopsy results No report yet.

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide — Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury — injured at work?

23. SIGNATURE W. R. Hodges, M. D. M. D. or other
Address Cumberland, Md. Date signed 7/18/47


RECEIVED
JUL 22 1947

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

61

05608

Reg. Dist. No. 2

1. PLACE OF DEATH:

County: Allegany

City or town: Flintstone

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 2 days

Hospital, institution, or street address where death occurred:

Flintstone

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md County: Allegany

City or town: Mt. Savage

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Rosetta Bridges

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	Widowed

6.(b) Name of husband or wife: Abraham J. Bridges

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): March 11, 1869

8. AGE: Years	Months	Days	If less than one day
78	3	20	hrs. min.

9. Birthplace: Bedford Co., Pa. (Town, county, and state)

10. Usual occupation: House wife

11. Industry or business: Own home

FATHER

12. Name: George Diehl

13. Birthplace: Pa.

MOTHER

14. Maiden name: Susan Means

15. Birthplace: Pa.

16. Informant: Pearl Bridges

Address: Mt. Savage, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: July 3, 1947 (month) (day) (year)

Cemetery or crematory: Methodist Cemetery

Location: Mt. Savage, Md

18. Funeral director: John T. Hofer

Address: Cumberland, Md.

19. July 2 1947 (Date rec'd by registrar) Nina L. Bender Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 1, 1947, at 2 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 1, 1947, to July 1, 1947, and that I last saw h alive on July 1, 1947

Immediate cause of death	DURATION
Acute myocarditis	1 day
Due to	
Due to	
Other conditions: Diabetes mellitus	?

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: J. A. Watson M.D. M. D. or other

Address: Cecil Orleans Md. Date signed: 7/2/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

932

05609

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:

County Allegany

City or town Cumberland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? —

Hospital, institution, or street address where death occurred: Memorial Hospital.

How long in hospital or institution? 4 days.

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Allegany

City or town Cumberland

(If outside city or town limits, write RURAL and give nearest town)

Street No. 209 Greene St.

(If rural, give LOCATION)

2.(a) If veteran, name war —

3.(a) FULL NAME Eleanor Katherine Bruce

3.(b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widowed

6.(b) Name of husband or wife Wm. M. Bruce

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) May 18, 1870

8. AGE: Years	Months	Days	If less than one day
77	2	4	...hrs. ...min.

9. Birthplace Cumberland Allegany Co., Md.
(Town, county, and state)

10. Usual occupation housewife

11. Industry or business —

FATHER 12. Name W. Milnor Roberts Jr.

FATHER 13. Birthplace Pennsylvania

MOTHER 14. Maiden name Bettie Humbird

MOTHER 15. Birthplace Maryland

16. Informant Richard Bruce

Address 209 Greene St. Cumberland, Md.

17. burial (Burial, cremation, or removal. Which?) Date thereof July 25, 1947 (month) (day) (year)

Cemetery or crematory Rose Hill Cemetery

Location Cumberland Maryland

18. Funeral director Louis Stein Inc.

Address Cumberland, Md.

19. July 24, 1947 (Date rec'd by registrar) Walter R. Frantz, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 22 1947 at 10:50 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 16 1947, to July 22 1947 and that I last saw her alive on July 22 1947

	DURATION
Immediate cause of death Myocardial Failure	?
Due to Hypertensive chronic nephritis	5 wks.
Due to Carcinoma of Left Breast	?
Other conditions Hypertension	?
Arteriosclerosis	?

(Include pregnancy within 3 months of death)

Major findings of operations extra systole

Date of op. .....

Autopsy results .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE Samuel Jacobs M.D. M. D. or other

Address 15 S. Liberty St. Date signed 7/31/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M


RECEIVED
JUL 29 1947
BURHAU V 8

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

94a

05610

CERTIFICATE OF DEATH

Reg. Diat. No. .....

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:

County Allegany

City or town Cumberland Md. (Amcelle)
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 48 Years

Hospital, institution, or street address where death occurred:
Amcelle, Cumberland, Md.

How long in hospital or institution? .....

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Md. County Allegany

City or town Cumberland
(If outside city or town limits, write RURAL and give nearest town)

Street No. 112 South Liberty
(If rural, give LOCATION)

2.(a) If veteran, name war World War 2

3.(a) FULL NAME Claude Estel Campbell

3.(b) Social Security Number 214-05-9444

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	married

6.(b) Name of husband or wife Sue Messick Campbell

6.(c) If alive, give age 43 years

7. Birth date of deceased (mo., day, yr.) June 9, 1899

8. AGE: Years	Months	Days	If less than one day
48	1	0	..... hrs. ..... min.

9. Birthplace Cumberland, Allegany Co., Maryland
(Town, county, and state)

10. Usual occupation Machinest

11. Industry or business Celenese Corporation

FATHER
12. Name Harry W. Campbell
13. Birthplace Huntersville, Va.

MOTHER
14. Maiden name Katherine Gulrey
15. Birthplace Cumberland, Md.

16. Informant Mrs. Sue Campbell

Address Greenspring, W. Va.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 7/11/47 (month) (day) (year)

Cemetery or crematory Greenmont Cemetery

Location Cumberland, Md.

18. Funeral director William H. Kight

Address Cumberland, Md.

19. July 11, 1947 (Date rec'd by registrar) M. V. Summers Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 9 1947, at 12.25 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....

and that I last saw him alive July 9 1947

Immediate cause of death	DURATION
Coronary occlusion	at once
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations .....

Date of op. .....

Autopsy results .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

Deputy Medical Examiner - Allegany Co

23. SIGNATURE H. V. Deming M.D. H. V. Deming M.D.
M. D. or other

Address Cumberland, Md. Date signed 7-12-47

Dr McCune

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

81a

05611 9

CERTIFICATE OF DEATH

Reg. Dist. No. 9

1. PLACE OF DEATH:

County Allegany

City or town Frostburg
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 5Days

Hospital, Institution, or street address where death occurred:
Miner's Hospital

How long in hospital or Institution? 5 Days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County Allegany

City or town Frostburg
(If outside city or town limits, write RURAL and give nearest town)

Street No. 76 Mechanic St.,
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Bernard Patrick Carter

3.(b) Social Security Number 214-07-2681

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife Edna McGown Carter

6.(c) If alive, give age 27yrs. years

7. Birth date of deceased (mo., day, yr.) March 18th., 1915

8. AGE: Years	Months	Days	If less than one day
32	4	10	....hrs. ....min.

9. Birthplace Hoffman Mines, Allegany, Md.
(Town, county, and state)

10. Usual occupation Spinner

11. Industry or business Celanese Corp. of America

FATHER 12. Name Thomas P. Carter

13. Birthplace Eckhart, Md.

MOTHER 14. Maiden name Catherine Groter

15. Birthplace Germany

16. Informant Mr. Cecil Seifarth Md.

Address I25 Mt. Pleasant St., Frostburg,

17. Burial (Burial, cremation, or removal. Which?) Date thereof July 30th 1947 (month) (day) (year)

Cemetery or crematory St. Michael's Cemetery

Location Frostburg, Md.

18. Funeral director Jacob Hafer

Address Frostburg, Md.

19. 7-30 1947 Mrs Maney K Roe Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH July 28 19 47 at 1.'24 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 23 19 47 to July 19 47 and that I last saw him alive on July 19 47

Immediate cause of death Streptococcus Meningitis — DURATION 5 Days

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE W O McCune M.D. M. D. or other

Address Frostburg Md Date signed 7-28-47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

45 f

05612

Reg. Dist. No. 4

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:

County Allegany

City or town Cumberland (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 40 years

Hospital, institution, or street address where death occurred: 406 Goethe St

How long in hospital or institution? —

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State Maryland County Allegany

City or town Cumberland (If outside city or town limits, write RURAL and give nearest town)

Street No. 406 Goethe St. (If rural, give LOCATION)

2.(a) If veteran, name war —

3.(a) FULL NAME Joseph Clarence Christopher

3.(b) Social Security Number 215-20-6394

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife Mary E "Koerner" Christopher 6.(c) If alive, give age 61 years

7. Birth date of deceased (mo., day, yr.) December 7, 1884

8. AGE: Years 62 | Months 7 | Days 9 | If less than one day ... hrs. ... min.

9. Birthplace Baltimore Maryland (Town, county, and state)

10. Usual occupation Painter

11. Industry or business Own business

FATHER 12. Name Joseph D. Christopher

13. Birthplace Baltimore, Maryland

MOTHER 14. Maiden name Elizabeth Ann Tovell

15. Birthplace Baltimore, Maryland

16. Informant Mrs J.C. Christopher

Address 406 Goethe St. Cumberland, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof July 19, 1947 (month) (day) (year)

Cemetery or crematory Rose Hill Cemetery

Location Cumberland, Maryland

18. Funeral director John J. Hafer

Address Cumberland, Maryland

19. July 17 1947 Hunter B. Frantz (Date rec'd by registrar) Reg'strar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 16, 1947, at 1030 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 1946 to July 16 1947 and that I last saw h... alive on July 16, 1947

Immediate cause of death	DURATION
Carcinoma Tonsil	13 mo
Due to	
Due to	
Other conditions Cachexia	

(Include pregnancy within 3 months of death)

Major findings of operations None Date of op.

Autopsy results None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE R. Bland Rudelsone M. D. or other

Address 122 So Centre Date signed 7-16-47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JUL 22 1947
BUBRAD V.S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

46f

05613

Reg. Dist. No. 6

1. PLACE OF DEATH:

County Allegany

City or town Rural McCoole, Md.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County Allegany

City or town Rural McCoole, Md.
(If outside city or town limits, write RURAL and give nearest town)

Street No. R#3 Box 72, Keyser, W.Va.
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Bertha Lee Climico

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband or wife Carmine Climco

6.(c) If alive, give age 54 years

7. Birth date of deceased (mo., day, yr.) July 13, 1898

8. AGE: Years	Months	Days	If less than one day
49	0	2	...hrs. ...min.

9. Birthplace Elk Garden, Mineral Co. W.Va.
(Town, county, and state)

10. Usual occupation Housewife

11. Industry or business

FATHER 12. Name Amos Leatherman

13. Birthplace Virginia

MOTHER 14. Maiden name Laura Shears

15. Birthplace Virginia

16. Informant Carmine Climico

Address R#3, Box 72, Keyser, W.Va.

17. Burial (Burial, cremation, or removal. Which?) Date thereof July 18, 1947 (month) (day) (year)

Cemetery or crematory Meadow Point

Location Keyser, W.Va.

18. Funeral director N.H. Rogers

Address Keyser, W.Va.

19. July 18 19 47 Registrar (Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH July 15, 1947, at 1:10 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 1947, to July 15 1947 and that I last saw h[illegible] alive on July 15, 1947

Immediate cause of death	DURATION
Cancer of the Gall bladder	1 yrs.
& metastasis to Liver, Lungs.	3 mo.
Due to & Ca of Jejunum	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations Cancer of Gall Bladder & metastasis to Liver Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Wm L McFarland M. D. or other

Address Keyser W. Va. Date signed 7-17-47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 96

CERTIFICATE OF DEATH

05614

Reg. Diat. No. 4

1. PLACE OF DEATH:
County: Allegany
City or town: Cumberland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 37 yrs
Hospital, institution, or street address where death occurred:
Allegany Hospital
How long in hospital or institution? —

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Allegany
City or town: Cumberland
(If outside city or town limits, write RURAL and give nearest town)
Street No. 119 S. Smallwood St.
(If rural, give LOCATION)
2.(a) If veteran, name war: —

3.(a) FULL NAME Martha G. Cloonan

3.(b) Social Security Number 214-05-5417

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband or wife: Thos L. Cloonan
6.(c) If alive, give age: ..... years

7. Birth date of deceased (mo., day, yr.): January 4, 1910

8. AGE: Years	Months	Days	If less than one day: hrs.	min.
37	6	4		

9. Birthplace: Cumberland Allegany Co. Md. (Town, county, and state)
10. Usual occupation: Telephone Operator
11. Industry or business: Celanese Corp.
FATHER 12. Name: John Minker
13. Birthplace: Cumberland Md
MOTHER 14. Maiden name: Mary C. Hipshmir
15. Birthplace: Germany
16. Informant: Thomas L. Cloonan
Address: 119 S. Smallwood St. Cumberland Md
17. Burial (Burial, cremation, or removal. Which?) Date thereof: July 11, 1947 (month) (day) (year)
Cemetery or crematory: St Peter's & Paul's Cemetery
Location: Cumberland Md.
18. Funeral director: Loma Stein, Inc.
Address: Cumberland, Md.
19. July 10, 1947 (Date rec'd by registrar) Walter R. Frantz, M.D. Acting Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 8 1947, at 7 P. M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 25 1947, to July 8 1947
and that I last saw h.. alive on July 8 1947
Immediate cause of death: Subarachnoid Hemorrhage — DURATION 2 weeks
Due to: Pulmonary Cystic Wilms — 4 years
Due to: —
Other conditions: —
(Include pregnancy within 3 months of death)
Major findings of operations: —
Date of op. —
Autopsy results: —
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE: B. M. Schmidlin M.D.
M. D. or other
Address: 41 Greene St. Cumberland Md. Date signed July 9, 1947

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9.45-15M

Mrs. Schindler

Within corporate limits

DR. W. F. WILLIAMS

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 47d

CERTIFICATE OF DEATH

05615

Reg. Dist. No. 4

1. PLACE OF DEATH:

County ALLEGANY

City or town CUMBERLAND (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred: MEMORIAL HOSPITAL

How long in hospital or institution? 18 DAYS

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State WEST VIRGINIA County MINERAL

City or town KEYSER (If outside city or town limits, write RURAL and give nearest town)

Street No. (If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME MR. ROY McKee COOK

3.(b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
MALE	WHITE	SINGLE

6.(b) Name of husband or wife

6.(c) If alive, give age ... years

7. Birth date of deceased (mo., day, yr.) OCTOBER 2, ~~1920~~ 1919

8. AGE: Years	Months	Days	If less than one day
~~27~~ 26	9	24	... hrs. ... min.

9. Birthplace WEST VIRGINIA (Town, county, and state)

10. Usual occupation FARMER

11. Industry or business

FATHER 12. Name ARTHUR T. COOK

13. Birthplace WEST VIRGINIA

MOTHER 14. Maiden name CATHERINE WALKER

15. Birthplace WEST VIRGINIA

16. Informant MEMORIAL HOSPITAL

Address CUMBERLAND, MARYLAND

17. Burial (Burial, cremation, or removal. Which?) Date thereof July 28 47 (month) (day) (year)

Cemetery or crematory Queenspoint

Location Keyser W. Va.

18. Funeral director T. N. L. Rogers Funeral Director

Address Keyser, W. Va

19. August 2, 1947 (Date rec'd by registrar) Winter R. Frantz M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH JULY 26, 1947, at 6:00 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 8 1947, to 7-26-1947

and that I last saw him alive on July 26 - 1947

Immediate cause of death Bronchogenic Carcinoma ~~Left~~ lung (Rt) ? ? ? ? ? ? ?

Due to It was impossible to contact his people for

Due to permission for a post mortem, undertaker

Other conditions removed body before we could contact family (Include pregnancy within 3 months of death)

DURATION

Major findings of operations none

Date of op. none

Autopsy results none

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ... Date of ...

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury ... Injured at work?

23. SIGNATURE W. F. Williams M.D. or other

Address Cumberland Date signed 8-2-47

Outside of City Limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

93d

05616

CERTIFICATE OF DEATH

Reg. Diat. No. 4

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:

County: Allegany

City or town: Near Cumberland, Rural

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred: Valley Road, R.F.D. #3,

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Allegany

City or town: [redacted] Cumberland

(If outside city or town limits, write RURAL and give nearest town)

Street No.: 818 Columbia Ave.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME: Mary A. Cordwell

3. (b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widowed

6.(b) Name of husband or wife: Julius Cordwell

6.(c) If alive, give age ? years

7. Birth date of deceased (mo., day, yr.): 1865 ?

8. AGE: Years 82 ? Months Days If less than one day hrs. min.

9. Birthplace: Morgan Co. W. Va. (Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business

FATHER — 12. Name: John Crone

13. Birthplace: W. Va.

MOTHER — 14. Maiden name: Anna E. Tederick

15. Birthplace: W. Va.

18. Informant: Mrs. D. N. Magruder

Address: 818 Columbia Ave. Cumberland, Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof July 17, 1947 (month) (day) (year)

Cemetery or crematory: Bethel Cem.

Location: Sleepy Creek, W. Va.

18. Funeral director: Charles L. George

Address: Cumberland, Md.

19. July 17 1947 (Date rec'd by registrar) Walter B. Grant M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 14, 1947 at 11:P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec 19 46 to July 14 1947

and that I last saw her alive on July 12 1947

Immediate cause of death	DURATION
(a) Cerebral hemorrhage	10 min
Due to (b) Chronic myocarditis	12 yrs
Due to (c) Generalized arteriosclerosis	12 yrs.
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: Arthur F. Jones M.D. M. D. or other

Address: 105 S. Centre St. Date signed 7-15-47

Within corporate limits

DR. JACOBSON

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

05617

Reg. Diat. No. 4

1. PLACE OF DEATH:

County ALLEGANY

City or town CUMBERLAND, MARYLAND
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred:
Memorial Hospital

How long in hospital or institution? 18 DAYS

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State MARYLAND County ALLEGANY

City or town ~~WESTERNPORT, MD.~~ WESTERNPORT, MD.
(If outside city or town limits, write RURAL and give nearest town)

Street No. ~~WESTERNPORT, MD.~~ Washington St.
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME
Edward
THOMAS CRABTREE

3.(b) Social Security Number
212-12-8159

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
MALE	WHITE	WIDOWED

6.(b) Name of husband or wife JULIA ANNA HAINES

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) 10/15/83

8. AGE: Years	Months	Days	If less than one day
63	9	4	....hrs. ....min.

9. Birthplace MD (Town, county, and state)

10. Usual occupation Axe House / Acting Chief of Police

11. Industry or business Celanese Corp. / Westernport, Md

FATHER
12. Name THOMAS CRABTREE
13. Birthplace MD

MOTHER
14. Maiden name EMMA ZIMMERLY
15. Birthplace MD

16. Informant Memorial Hosp. Cumberland, Md.
Address

17. Burial (Burial, cremation, or removal. Which?) Date thereof July 22 1947 (month) (day) (year)
Cemetery or crematory Thlas Cemtery
Location Westernport, Md

18. Funeral director Ellsworth D. Boal
Address Westernport, Md

19. July 19 1947 Winter R. Bantz M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH JULY 19, 1947 19.... at 11:50 A M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from July 1 1947 to July 19 1947 and that I last saw him alive on July 19 1947

Immediate cause of death	DURATION
Uremia	3 weeks
Due to: Paralysis 5th & 7th Nerves (Combination)	3 yrs?
Due to:	
Other conditions Cerebro Spinal Syphilis ?	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE James W. Jacobson M. D. or other

Address U.S. Tuberculosis Hosp. Date signed 7/19/47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15


RECEIVED
JUL 22 1941
BUREAU

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 93d

CERTIFICATE OF DEATH

05618

Reg. Dist. No. 4

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:

County Allegany

City or town Cumberland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 40 yrs

Hospital, institution, or street address where death occurred: 339 Frederick St. (Rear)

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Allegany

City or town Cumberland

(If outside city or town limits, write RURAL and give nearest town)

Street No. 339 Frederick St. (Rear)

(If rural, give LOCATION)

2.(a) Ll veteran, name war

3. (a) FULL NAME Elizabeth (Liggie) Darr

3. (b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	Colored	Widowed

6.(b) Name of husband or wife Oscar Darr

6.(c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) — 1873

8. AGE: Years 84 | Months — | Days | If less than one day ... hrs. ... min.

9. Birthplace Montgomery Co Md. (town, county, and state)

10. Usual occupation Housework

11. Industry or business at Home

FATHER 12. Name Rodney Washington

13. Birthplace Md

MOTHER 14. Maiden name Sarah Ann —

15. Birthplace Md.

16. Informant Mary Moore

Address 60 St & Felix St Brooklyn (1) N. Y.

17. Burial (Burial, cremation, or removal? Which?) Date thereof July 17 47 (month) (day) (year)

Cemetery or crematory Sunnyer Cem.

Location Cumberland Md.

18. Funeral director Louis Stein Inc

Address Cumberland.

19. July 17 1947 Clinton L. Trauth, M.D. Registrar

(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH July 15 1947, at 7 A.M.

21. I CERTIFY, that death occurred on the date above stated; that I attended deceased from July 2 1947, to July 15 1947

and that I last saw h alive on July 2 1947

Immediate cause of death	DURATION
Chronic myocarditis	1 yr
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operation Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE L Mains MD M. D. or other

Address 59 Greene St. Date signed 7-16-47

Bringas

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 93d

Dr P. E. Berry 05619

CERTIFICATE OF DEATH

Reg. Dist. No. 6

1. PLACE OF DEATH:

County: Allegany

City or town: Westernport

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 3 years

Hospital, institution, or street address where death occurred:

119 Wood Street

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Allegany

City or town: Westernport

(If outside city or town limits, write RURAL and give nearest town)

Street No.: 119 Wood Street

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

FLORENCE DAVIS

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widowed

6.(b) Name of husband or wife: Jonathon W. W. Davis

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): July 10, 1852

8. AGE: Years	Months	Days	If less than one day
95		2	hrs. min.

9. Birthplace: Brownsville, Fayette, Penna.
(Town, county, and state)

10. Usual occupation: House wife

11. Industry or business: Own home

FATHER
12. Name: George R. Murphy
13. Birthplace: Baltimore, Maryland

MOTHER
14. Maiden name: Miriah C. Morris
15. Birthplace

16. Informant: Georeg Davis

Address: 119 Wood Street, Westernport, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: July 15, 1947 (month) (day) (year)

Cemetery or crematory: Philos Cemetery

Location: Westernport, Md

18. Funeral director: Ellsworth S. Boal

Address: Westernport, Md

19. July 14 1947 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 12 1947 at 10:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 1 1947, to July 12 1947 and that I last saw h alive on 1947

Immediate cause of death	DURATION
Hypostatic Pneumonia	12 days
Due to Senility	
Due to Arteris selerotic Cardio Vascular Disease (8/27/47-as)	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operation:

Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: P E Berry M.D. M. D. or other

Address: Piedmont W Va Date signed: 7/14/47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

932

C6461

Reg. Dist. No. 10

1. PLACE OF DEATH:
County Allegany
City or town Barrellville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 15 yrs
Hospital, Institution, or street address where death occurred:
on Wallaston Road
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md. County Allegany
City or town Barrellville
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME George Edward Diehl

3.(b) Social Security Number 215-10-1311

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Widowed

6.(b) Name of husband or wife Agnes Virginia

6.(c) If alive, give age ... years

7. Birth date of deceased (mo., day, yr.) July 31 St. 1873

8. AGE: Years 73 | Months 6 | Days 17 | If less than one day ... hrs. ... min.

9. Birthplace Edenmoyer Bedford Co. Pa.
(Town, county, and state)

10. Usual occupation Miner

11. Industry or business Coal

FATHER
12. Name George Diehl
13. Birthplace Pennsylvania

MOTHER
14. Malden name Susan Myers
15. Birthplace Pennsylvania

16. Informant Mrs. D. Virginia Diehl
Address Bridgeport, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof July 22-1947 (month) (day) (year)
Cemetery or crematory Allegany
Location Frostburg, Md.

18. Funeral director Isaac Baker
Address Frostburg, Md.

19. July 20 1947 Veronica McDevitt
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 19 1947 at 11:00 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from January 1946 to July 19 1947
and that I last saw him alive on July 18 1947

Immediate cause of death Myocarditis — DURATION: Several Years

Due to

Due to

Other conditions Chronic Bronchial Asthma — DURATION: Several years

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE William E. Moseley M. D.
M. D. or other
Address Mt Savage Md. Date signed 7-19-1947

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

97

05620

Reg. Dist. No. 6

M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

1. PLACE OF DEATH:
County: Allegany
City or town: McCoole
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 17 yrs.
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Allegany
City or town: McCoole
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: Kathryn Sophia Dittmar

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widow

6.(b) Name of husband or wife: Louis Dittmar
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Dec. 16, 1856

8. AGE: Years	Months	Days	If less than one day
90	6	28	hrs. min.

9. Birthplace: Morgan Co., W. Va.
(Town, county, and state)
10. Usual occupation: At home
11. Industry or business

FATHER
12. Name: Nelson Caldwell
13. Birthplace: do not know

MOTHER
14. Maiden name: Mary Pentongy
15. Birthplace: do not know

16. Informant: Mrs. W.B. Burke
Address: McCoole, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 7/16/1947 (month) (day) (year)
Cemetery or crematory: xxxx Greenway
Location: Berkeley Springs, W. Va.
18. Funeral director: B.W. Markwood
Address: Keyser, W. Va.

19. July 15 1947 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 14, 1947 at 3:15 A M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from June 18 1946 to July 13 1947 and that I last saw her alive on July 13 1947

Immediate cause of death	DURATION
Cerebral Arteriosclerosis	5 months
General Arterio sclerosis	5 years
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE: E.G. Courrier M. D. or other
Address: Keyser W. Va. Date signed 7/14/47

Within corporate limits

DR. JACOBSON

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

1454 CERTIFICATE OF DEATH

05621

Reg. Dist. No. 4

1. PLACE OF DEATH:

County ALLEGANY

City or town CUMBERLAND

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 11 Days

Hospital, institution, or street address where death occurred:

MEMORIAL HOSPITAL

How long in hospital or institution? 11 DAYS

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State WEST VIRGINIA County MINERAL

City or town ELK GARDEN

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME MR. STEPHEN A. DIXON

3.(b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
MALE	WHITE	MARRIED

6.(b) Name of husband or wife LULA BARRICK

6.(c) If alive, give age 62 years

7. Birth date of deceased (mo., day, yr.) MARCH 4, 1881

8. AGE: Years	Months	Days	If less than one day
66	4	6	...hrs. ...min.

9. Birthplace WEST VIRGINIA (Town, county, and state)

10. Usual occupation FARMER

11. Industry or business

FATHER

12. Name STEPHEN DIXON

13. Birthplace WEST VIRGINIA

MOTHER

14. Maiden name ELIZABETH KITZMILLER

15. Birthplace WEST VIRGINIA

16. Informant MEMORIAL HOSPITAL

Address CUMBERLAND, MD

17. Burial (Burial, cremation, or removal. Which?) Date thereof 7/13/47 (month) (day) (year)

Cemetery or crematory Nethken Hill Cemetery

Location Elk Garden, W. Va.

18. Funeral director William H. Kight

Address Cumberland, Md.

19. July 12 1947 (Date rec'd by registrar) Whitley R. Crawley, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH JULY 10, 1947, at 9:45 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 12 1947 to July 10 1947 and that I last saw h[illegible] alive on July 10 1947

	DURATION
Immediate cause of death Carcinoma Transverse Colon & Metastasis	2
Due to Ca Liver	2
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations None

Date of op. 7/7/47

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE [signature] M. D. or other

Address 15 S. Liberty St. Date signed 7/11/47

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Be sure correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

93d

05622

CERTIFICATE OF DEATH

Reg. Diat. No. 4

1. PLACE OF DEATH:
County Allegany
City or town Cumberland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 3 yrs.
Hospital, Institution, or street address where death occurred:
Allegany County Infimary
How long in hospital or institution? 3 Yrs.

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md. County Allegany
City or town [redacted] Eckhart
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Bernice O. Dudley

3.(b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widowed

6.(b) Name of husband or wife Fred Dudley
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Oct. 1st., 1869

8. AGE: Years 77 | Months 9 | Days 15 | If less than one day ..... hrs. ..... min.

9. Birthplace Maryland Eckhart, Allegany Co.
(Town, county, and state)

10. Usual occupation Imfirmary Patient

11. Industry or business

FATHER 12. Name John R. McMullen
13. Birthplace Maryland

MOTHER 14. Maiden name Don't know
15. Birthplace " "

16. Intormant Mrs. Guy T. Billmyer
Address 2853 Chesterfield Ave. Balto, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof July 19th. 47 (month) (day) (year)
Cemetery or crematory Eckhart Cemetery
Location Eckhart, Md.

18. Funeral director Jacob Hafer
Address Frostburg, Md.

19. July 19, 1947 Winter R. Frantz M.D. Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH July 16 1947 at 10 15 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec 1946 to July 16 1947 and that I last saw her alive on July 15 1947

Immediate cause of death	DURATION
Acute Myocardial Failure	10 min
Due to Chronic Myocarditis	15 yrs
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operation ..... Date of op. .....

Autopsy results .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of .....
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work? .....

23. SIGNATURE Arthur F. Jones M.D.
M. D. or other
Address 110 S. Centre St. Date signed 7-18-47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 1318

1454

CERTIFICATE OF DEATH

05623

Reg. Dist. No. 4

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Use correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:

County: Allegany

City or town: Cumberland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 35 Years

Hospital, institution, or street address where death occurred:
117 South Centre Street

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Allegany

City or town: Cumberland
(If outside city or town limits, write RURAL and give nearest town)

Street No. 117 South Centre Street
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: Charlotte Kathern Flanagan

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widow

6.(b) Name of husband or wife: Sterling P. Flanagan

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): March 28 1873

8. AGE: Years	Months	Days	If less than one day
74	3	11	..... hrs. ..... min.

9. Birthplace: Hancock, Washington Co, Maryland
(Town, county, and state)

10. Usual occupation: House

11. Industry or business: "

FATHER
12. Name: Lloyd Barnes
13. Birthplace: Unknown

MOTHER
14. Maiden name: Unknown
15. Birthplace: Fulton Co, Penna

16. Informant: Charles E. Flanagan
Address 509 Shriver Ave, Cumberland, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 7/12/47 (month) (day) (year)

Cemetery or crematory: Moore Cemetery

Location: Porterwood, WVA

18. Funeral director: William H. Kight

Address: Cumberland, Md.

19. July 12, 1947 (Date rec'd by registrar) Winter Roberts M.D. acting Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 9 1947 at 3-30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 25 1947 to July 9 1947 and that I last saw h.. alive on July 9, 1947

	DURATION
Immediate cause of death: Uremic Coma	2 days
Due to: Chr Nephritis	
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operation: ..... Date of op. .....

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: [signature] M.D. M. D. or other

Address ..... Date signed 7/18/47

Outside of City Limits

Dick Dean

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 94a

CERTIFICATE OF DEATH

Reg. Diat. No. 05624

1. PLACE OF DEATH:

County: Allegany

City or town: Mexico Farms, Near Cumberland Md.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 5 years

Hospital, Institution, or street address where death occurred:
Mexico Farms RD#4 Cumb Md.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Allegany

City or town: Mexico Farms, Near Cumberland, Md.
(If outside city or town limits, write RURAL and give nearest town)

Street No.: Rural, Near Cumberland, Md.
(If rural, give LOCATION)

2.(a) If veteran, name war: None

3.(a) FULL NAME: Thomas Hillard Forsyth

3.(b) Social Security Number: 705-05-5313

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Divorced

6.(b) Name of husband or wife:

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): July 17, 1887

8. AGE: Years	Months	Days	If less than one day
60	0	9	hrs. min.

9. Birthplace: Clearspring, Washington, Maryland (Town, county, and state)

10. Usual occupation: Boilermaker

11. Industry or business: B&O R.R.

FATHER
12. Name: Jocob Patrick Forsyth
13. Birthplace: Clearspring, Maryland

MOTHER
14. Maiden name: Rosanna Mills
15. Birthplace: Clearspring, Maryland

16. Informant: Mrs. G. W. Collins
Address: RD #4. Mexico Farms, Cumberland, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: July 29, 1947 (month) (day) (year)

Cemetery or crematory: Forsyth Family Cemetery

Location: Clearspring, Maryland

18. Funeral director: John J. Adler

Address: Cumberland, Maryland

19. July 29, 1947 (Date rec'd by registrar) White R. Trautz, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 26 1947 at 5 30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 9/16/46 19 to 7/26/47 19
and that I last saw alive on 7/26/47 19

	DURATION
Immediate cause of death: Coronary Thrombosis	15 min.
Due to: Arteriosclerosis	
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: [signature] M.D. or other

Address: Cumberland Md. Date signed: 7/29/47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

Within corporate limits

Dr W. F. Wms

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

49a

05625

CERTIFICATE OF DEATH

Reg. Dist. No. 4

Page

1. PLACE OF DEATH:

County ALLEGANY

City or town CUMBERLAND MARYLAND (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 77 YRS.

Hospital, institution, or street address where death occurred: MEMORIAL HOSPITAL

How long in hospital or institution? 28 DAYS

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State MARYLAND County ALLEGANY

City or town CUMBERLAND (If outside city or town limits, write RURAL and give nearest town)

Street No. 841 CAMDEN AVE (If rural, give LOCATION)

2.(a) If veteran, name war ———

3. (a) FULL NAME ANNA MOLLIE FREY

3. (b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
FEMALE	WHITE	WIDOWED

6.(b) Name of husband or wife FRANK FREY

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) NOV 3 1874

8. AGE: Years	Months	Days	If less than one day
72	8	16	..... hrs. ..... min.

9. Birthplace CUMBERLAND MD. (Town, county, and state)

10. Usual occupation HOUSEWIFE

11. Industry or business 0

FATHER 12. Name KIENHOFER, ANTHONY

FATHER 13. Birthplace GERMANY

MOTHER 14. Maiden name SCHMIDT, CATHERINE

MOTHER 15. Birthplace GERMANY

16. Informant Mrs Richard Durrell

Address Cumberland

17. Burial (Burial, cremation, or removal. Which?) Date thereof July 22 47 (month) (day) (year)

Cemetery or crematory St Peter & Pauls Cem.

Location Cumberland

18. Funeral director Louis Stein & Son

Address Cumberland.

19. July 21, 1947 (Date rec'd by registrar) Wilter R. Frantz M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH JULY 19 1947, at NOON. 12:00

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 20 1947, to July 19 1947

and that I last saw h[illegible] alive on July 19 1947

	DURATION
Immediate cause of death Carcinomatosis of Abdominal Viscera	
Due to	
Due to	
Other conditions Probably Carcinoma of ovary	

(Include pregnancy within 3 months of death)

Major findings of operations See above Date of op. 7-11-47

Autopsy results None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE W. F. Williams M. D. or other

Address Cumberland Date signed 7-19-47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9.45-15M

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 170c

CERTIFICATE OF DEATH

05626

Reg. Dist. No. 4

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:
County Allegany
City or town Cumberland Md.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 13.1/2 hours
Hospital, Institution, or street address where death occurred:
Allegany Hospital
How long in hospital or institution? 13.1/2 hours

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md County Allegany
City or town Cresaptown Md
(If outside city or town limits, write RURAL and give nearest town)
Street No. Winchester Ave.
(If rural, give LOCATION)
2.(a) If veteran, name war World War 2

3.(a) FULL NAME Charles Foster Glover

3.(b) Social Security Number 220-16-7097

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	white	Single

6.(b) Name of husband or wife
6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 24-1924

8. AGE: Years	Months	Days	If less than one day
23	5	3	hrs. min.

9. Birthplace Uniontown, Fayette Co., Pa.
(Town, county, and state)
10. Usual occupation Textile Worker
11. Industry or business Celanese Corp. of America
FATHER 12. Name Foster C. Glover
13. Birthplace Hazelton, W.Va.
MOTHER 14. Maiden name Virginia B. Mc Gettigan
15. Birthplace Accident, Md.
16. Informant Foster C. Glover
Address Cresaptown, Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof July 30, 1947 (month) (day) (year)
Cemetery or crematory Hillcrest Cemetery
Location Cumberland, Md.
18. Funeral director John J. Hafer
Address Cumberland, Md.
19. July 30 1947 (Date rec'd by registrar) Wintes R. Frank M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 27 1947 at 1.30P.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ... 19... to ... 19...
and that I last saw him alive Dead July 27 1947

Immediate cause of death	DURATION
Fractured cervical vertebrae & severe concussion of brain	14.1/2 hours
Due to Automobile accident	
Due to	
Other conditions fracture left malar bone	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide accident Date of 7-27-47
Where did injury occur? Route 36 Barrelsville Junction, Wellersburg and Mt. Savage road. Allegany (County) Md. (State)
Injured at home, farm, industry, public place (where?)
Means of injury Auto ran into a rock side of road. Injured at work? no

Deputy Medical Examiner - Allegany Co

23. SIGNATURE H. V. Deming M.D. H.V. Deming M.D.
M. D. or other
Address Cumberland Md. Date signed 7-28-47

DR. GROVE

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 123

CERTIFICATE OF DEATH

05628

18

Reg. Dist. No. 4

1. PLACE OF DEATH:

County ALLEGANY

City or town CUMBERLAND, MARYLAND (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address (If not in hospital) where death occurred Memorial Hospital

How long in hospital or institution? 8 DAYS

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State W. VA. County Mineral

City or town RIDGELEY, W. VA. (If outside city or town limits, write RURAL and give nearest town)

Street No. 30 River View Ave. (If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME JESSE HALTERMAN

3.(b) Social Security Number 705-10-7321

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
MALE	WHITE	MARRIED

6.(b) Name of husband or wife VIRGINIA ZIMMERS

6.(c) If alive, give age 41 years

7. Birth date of deceased (mo., day, yr.) AUGUST 21, 1898

8. AGE: Years 48 | Months 10 | Days 28 | If less than one day ..... hrs. ..... min.

9. Birthplace W.VA. (Town, county, and state)

10. Usual occupation CARMAN WESTERN MD. R.R.

11. Industry or business W. Md. Railway

FATHER 12. Name LEE HALTERMAN

13. Birthplace W.VA

MOTHER 14. Maiden name MOYER Lula

15. Birthplace W.V a

16. Informant Mrs. Virginia Halterman

Address 30 River View Ave. Ridgeley, W. Va.

17. Burial (Burial, cremation, or removal. Which?) Date thereof July 19, 1947 (month) (day) (year)

Cemetery or crematory Fort Ashby Cem.

Location Fort Ashby W. Va.

18. Funeral director Charles L. George

Address Cumberland, Md.

19. July 19, 1947 (Date rec'd by registrar) Winter R. Frank, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH JULY 17, 1947, at 7:41 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 7-1- 1947 to 7-17 1947 and that I last saw h.. alive on July 17 1947

Immediate cause of death	DURATION
(a) Chronic Nephritis	6 mos
Last disease	
Due to (b) Thrombosis	4 Days
Due to (c) Thrombosis - femoral artery - left	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operation Resection L. small intestine

Date of op. 7-16-'47

Autopsy results none

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE D. B. Jones M.D. M. D. or other

Address Medical Bldg Cumberland, Md. Date signed 7-17-47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M


RECEIVED
JUL 22 1947
BUREAU

Dr. Louis Briggs

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 93d

CERTIFICATE OF DEATH

Reg. Dist. No. 0562 9 1

1. PLACE OF DEATH:

County Allegany

City or town Oldtown, Maryland, RD #1
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 70 years

Hospital, Institution, or street address where death occurred:
Oldtown, Md. RD #1

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County Allegany

City or town Rural near Oldtown, Md.
(If outside city or town limits, write RURAL and give nearest town)

Street No. RD #1
(If rural, give LOCATION)

2.(a) If veteran, name war None

3.(a) FULL NAME Willie Marion Hartley

3.(b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife Laura "Blackburn" Hartley

6.(c) If alive, give age 66 years

7. Birth date of deceased (mo., day, yr.) November 13, 1876

8. AGE: Years	Months	Days	If less than one day
70	8	14	..... hrs. ..... min.

9. Birthplace Oldtown, Allegany, Maryland
(Town, county, and state)

10. Usual occupation Farmer

11. Industry or business Own Farm

FATHER
12. Name Riley Hartley
13. Birthplace Oldtown, Maryland

MOTHER
14. Maiden name Malinda Reckley
15. Birthplace Oldtown, Maryland.

16. Informant Mrs. W. M. Hartley
Address RD #1 Oldtown, Md.

17. Burial Date thereof July 30, 1947
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Hartley Family Cemetery

Location RD #1 Oldtown, Md.

18. Funeral director John J. Hafer

Address Cumberland, Md.

19. July 30, 1947 Mrs. C. A. Shamholtz
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 27 1947 at 4 00 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 12 1947 to July 27 1947

and that I last saw h[illegible] alive on July 23 1947

Immediate cause of death	DURATION
cellulitis left [illegible]	14 days
Due to	
Due to	
Other conditions chronic myocarditis 2 years	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE C. Mings M.D.
M. D. or other

Address 59 Queen St. Date signed 7-28-47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH NONFADING INK. Supply every item of information carefully. Incorrect or illegible is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 46d

CERTIFICATE OF DEATH

05630

Reg. Dist. No. 4

1. PLACE OF DEATH:
County ALLEGANY
City or town CUMBERLAND
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 13 DAYS
Hospital, Institution, or street address where death occurred:
MEMORIAL HOSPITAL
How long in hospital or institution? 13 DAYS

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State MARYLAND County ALLEGANY
City or town CUMBERLAND
(If outside city or town limits, write RURAL and give nearest town)
Street No. 112 N. CEDAR ST
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME HAUGER, WARD MR

3.(b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
MALE	WHITE	MARRIED

6.(b) Name of husband or wife CORNWELL, NINA
6.(c) If alive, give age 50 years

7. Birth date of deceased (mo., day, yr.) AUG. 16, 1896

8. AGE: Years	Months	Days	If less than one day
50	10	25	hrs. min.

9. Birthplace W. VA (Town, county, and state)
10. Usual occupation JEWLER
11. Industry or business SELF

FATHER
12. Name HAUGER, JOHN
13. Birthplace W.VA

MOTHER
14. Maiden name SMITH, SAVILLE
15. Birthplace W.VA

16. Informant Mrs. Nina L. Hauger
Address 112 N. Cedar St. Cumberland, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof July 14, 1947 (month) (day) (year)
Cemetery or crematory Hillcrest Burial Park
Location Cumberland, Md.

18. Funeral director Charles L. George
Address Cumberland, Md.

19. July 14, 1947 (Date rec'd by registrar) Winter R. Frantz M.D. acting Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 11, 1947 at 9:10 AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 27, 1947, to July 11, 1947 and that I last saw him alive on July 11, 1947

Immediate cause of death Carcinoma Recto-sigmoid junction of large intestine with perforation Due to Ruptured pericolitis — DURATION June 27, (1947)

Due to

Other conditions Myocardial weakness and decompensation (Include pregnancy within 3 months of death) ?

Major findings of operation Carcinoma recto-sigmoid junction with perforation Date of op. June 27 (1947)

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

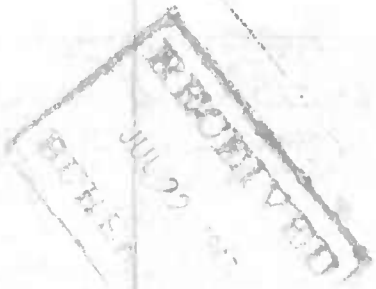
22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide No Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of Injury Injured at work?

23. SIGNATURE Wyllys Faw Jr. M.D. M. D. or other
Address Cumberland Md. Date signed July 11, 47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M


RECEIVED

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 112a

CERTIFICATE OF DEATH

S 05631

Reg. Diat. No. 4

1. PLACE OF DEATH:

County Allegany

City or town Cumberland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 1½ Days

Hospital, institution, or street address where death occurred:

Memorial Hospital

How long in hospital or institution? 1½ days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State West Virginia County Hampshire

City or town Romney

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME Mr. Wade Herriott

3. (b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single

6.(b) Name of husband or wife

6.(c) If alive; give age years

7. Birth date of deceased (mo., day, yr.) December 22 1881

8. AGE: Years	Months	Days	If less than one day
65	6	17	hrs. min.

9. Birthplace West Virginia (Town, county, and state)

10. Usual occupation Farmer and Stock breeder

11. Industry or business

FATHER 12. Name Franklin Herriott

13. Birthplace West Virginia

MOTHER 14. Maiden name Susan Reese

15. Birthplace West Virginia

16. Informant Memorial Hospital

Address Cumberland, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 7/13/47 (month) (day) (year)

Cemetery or crematory Springfield Cemetery

Location Springfield, W. Va.

18. Funeral director Ralph Guthrie

Address Springfield, W. Va.

19. July 11, 1947 (Date rec'd by registrar) Winter L. Krantz, M.D. acting Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 9 1947 at 12:35 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 7 1947 to July 9 1947 and that I last saw him alive on July 9, 1947

Immediate cause of death	DURATION
Peritonitis	
Due to Ruptured Gastric ulcer	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations Ruptured gastric ulcer Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE W. A. Grace M. D. or Other

Address Cumberland Date signed July 9-47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

Within corporate limits

DR. WHITWORTH

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

588

05632

Reg. Dist. No. 4

1. PLACE OF DEATH:

County: ALLEGANY

City or town: CUMBERLAND

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 25 days

Hospital, institution, or street address where death occurred:

MEMORIAL HOSPITAL

How long in hospital or institution? 25 DAYS

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: MARYLAND County: ALLEGANY

City or town: FLINTSTONE

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME: MRS. PAULINE HINKLE

3. (b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
FEMALE	WHITE	MARRIED

6.(b) Name of husband or wife: LESTER HINKLE

6.(c) If alive, give age: 38 years

7. Birth date of deceased (mo., day, yr.): MARCH 19, 1909

8. AGE: Years	Months	Days	If less than one day
38	4	12	..... hrs. ..... min.

9. Birthplace: WEST VIRGINIA Pow Pow (Town, county, and state)

10. Usual occupation: HOUSEWIFE

11. Industry or business: Own home

FATHER

12. Name: C. P. ALDERTON

13. Birthplace: WEST VIRGINIA

MOTHER

14. Maiden name: NELLIE HAYNAKER

15. Birthplace: WEST VIRGINIA

16. Informant: MEMORIAL HOSPITAL

Address: CUMBERLAND, MARYLAND

17. Burial (Burial, cremation, or removal. Which?) Date thereof August 2, 1947 (month) (day) (year)

Cemetery or crematory: Hillcrest Cemetery

Location: Cumberland, Md.

18. Funeral director: John J. Hafer

Address: Cumberland, Md.

19. Aug 1, 1947 (Date rec'd by registrar) Miles R. Fantz, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: JULY 31, 1947, at 7:37 AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 6 July 1947, to 31 July 1947, and that I last saw h... alive on 31 July 1947.

	DURATION
Immediate cause of death: Cardiac Failure	
Due to: Acute dilation Heart	
Due to: Rheumatic Fever	
Due to: Bacterial Endocarditis	
Due to: Encephalitis.	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Fuller B Hutton M.D. M. D. or other

Address: 112 Bedford St. Date signed: 31 July 47.

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

Within corporate limits. L. R. Meyers

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

89a

05633

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:

County ALLEGANY

City or town CUMBERLAND
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? ~~13 DAYS~~ 4 years

Hospital, institution, or street address where death occurred:
MEMORIAL HOSPITAL

How long in hospital or institution? 13 DAYS

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State MARYLAND County ALLEGANY

City or town ~~Was~~ CUMBERLAND, Rural
(If outside city or town limits, write RURAL and give nearest town)

Street No. Rt. 2
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME

CARL HUFFMAN JR.

3.(b) Social Security Number

None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
MALE	WHITE	SINGLE

6.(b) Name of husband or wife

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) FEB. 17, 1931

8. AGE: Years	Months	Days	If less than one day
16	4	28	..... hrs. ..... min.

9. Birthplace Davis, Tucker Co. W. Va.
(Town, county, and state)

10. Usual occupation Student

11. Industry or business High School

FATHER 12. Name CARL HUFFMAN

13. Birthplace WEST VIRGINIA, Dry Fork

MOTHER 14. Maiden name Texie Huffman

15. Birthplace WEST VIRGINIA, Dry Fork

16. Informant Carl Huffman, Sr.

Address Rt. 2, Cumberland, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof July 19, 1947 (month) (day) (year)

Cemetery or crematory Huffman Family Cemetery

Location near Davis, W. Va.

18. Funeral director John J. Hafer

Address Cumberland, Md

19. July 17 1947 Hunter G. Stantz
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 15 19 47 at 4.45 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 24 19 47 to July 15 19 47 and that I last saw him alive on July 15 19 47

Immediate cause of death	DURATION
Abscess of Brain	30 days
Due to Chronic Mastoiditis	5 yrs
Due to Chronic Otitis Media	5 yrs
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations Mastoiditis and Abscess of Brain Date of op. 7/3/47 & 7/10/47

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE L. R. Meyers M. D.
M. D. or other

Address Cumberland, Md Date signed 7/16/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M


RECEIVED
JUL 22 1947
BUREA

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 93d

05634

CERTIFICATE OF DEATH

Reg. Diat. No. 1

1. PLACE OF DEATH:
County: Allegany
City or town: Little Orleans (rural)
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 87 yrs
Hospital, Institution, or street address where death occurred:
R.F.D. 1.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Allegany
City or town: Little Orleans (rural)
(If outside city or town limits, write RURAL and give nearest town)
Street No. R.F.D. 1.
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME John Marshall Kaseeamp

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	White	married

6.(b) Name of husband or wife: Nellie Kaseeamp
6.(c) If alive, give age: 84 years

7. Birth date of deceased (mo., day, yr.): Dec. 29, 1859

8. AGE: Years	Months	Days	If less than one day
87	6	18	hrs. min.

9. Birthplace: Allegany Co., Md. (Town, county, and state)
10. Usual occupation: Farmer
11. Industry or business: Own farm

FATHER
12. Name: Frederick Kaseeamp
13. Birthplace: Germany

MOTHER
14. Maiden name: Isabel Duff
15. Birthplace: Scotland

16. Informant: James Kaseeamp
Address: Little Orleans, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: July 19, 1947 (month) (day) (year)
Cemetery or crematory: St. Patrick cemetery
Location: Little Orleans Md.

18. Funeral director: H. Wayne George
Address: Cumberland, Md.

19. July 19 1947 (Date rec'd by registrar) Mrs C.A. Shanholtz Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 17 1947 at 4:30 A. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 17 1947 to July 17 1947 and that I last saw him alive on July 1 1947

Immediate cause of death	DURATION
Myocardial degeneration	?
Due to	
Due to	
Other conditions: Rheumatism	18 yrs

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

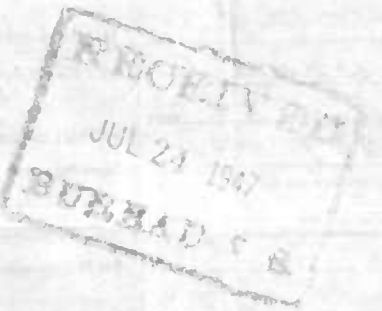
22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: J. A. Watson M. D. or other
Address: Little Orleans, Md. Date signed: 7/17/47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15


RECEIVED
JUL 24 1947
BUREAU

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 95

Bureau 05636

CERTIFICATE OF DEATH

Reg. Diat. No. 4

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:

County Allegany

City or town Cumberland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 43 yrs. 7 mo. 23 da

Hospital, institution or street address where death occurred:
Allegany Hospital

How long in hospital or institution? 30 minutes

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County Allegany

City or town Cumberland
(If outside city or town limits, write RURAL and give nearest town)

Street No. 318 Holland St.
(If rural, give LOCATION)

2.(a) If veteran, name war —

3.(a) FULL NAME Mary Leota Kesler

3.(b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband or wife Bernard L. Kesler

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Nov 17 1903

8. AGE: Years	Months	Days	If less than one day
43	7	23	..... hrs. ..... min.

9. Birthplace Cumberland Md.
(Town, county, and state)

10. Usual occupation Housewife

11. Industry or business at Home

FATHER 12. Name Charles Pollock

13. Birthplace W. Va.

MOTHER 14. Maiden name Anna Jeanette Folk

15. Birthplace Md.

16. Informant Bernard Kesler

Address Cumberland

17. Burial Date thereof July 8 47
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory St Peter & Pauls Cem

Location Cumberland Md

18. Funeral director Louis Stein Sons

Address Cumberland.

19. July 7 1947 Walter R. Frantz M.D. Registrar
(Date rec'd by registrar) Acting

MEDICAL CERTIFICATION

20. DATE OF DEATH July 5 1947, at 1:15 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 1 1943, to July 5 1947

and that I last saw h.. alive on July 5 1947

Immediate cause of death	DURATION
Congestive heart failure	1 yr
Due to rheumatic heart	5 yrs
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op. .....

Autopsy results rheumatic heart

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE L. Wings M.D.
M. D. or other

Address 59 Greene St. Date signed 7-5-47

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 13/a

CERTIFICATE OF DEATH

S 05637 4
Reg. Diat. No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:

County: Allegany

City or town: Cumberland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 11 Days

Hospital, institution, or street address where death occurred:
437 Chestmut St

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: West Virginia County: Hampshire

City or town: Romney
(If outside city or town limits, write RURAL and give nearest town)

Street No.: R.F.D.
(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: Alice Kessel

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband or wife: Charles A. Kessel

6.(c) If alive, give age: 78 years

7. Birth date of deceased (mo., day, yr.): April 11 1880

8. AGE: Years	Months	Days	If less than one day
67	2	20	hrs. min.

9. Birthplace: Romney, Hampshire Co, West Virginia
(Town, county, and state)

10. Usual occupation: House

11. Industry or business: "

FATHER
12. Name: Rex Clemm
13. Birthplace: Romney, W. Va.

MOTHER
14. Maiden name: Alberta Bell
15. Birthplace: Romney, W. Va.

16. Informant: Charles A. Kessel
Address: 437 Chestmut St, Cumberland, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: July 3 1947 (month) (day) (year)

Cemetery or crematory: Ebenezer Cemetery

Location: Romney, W. Va.

18. Funeral director: William H. Kight

Address: Cumberland, Md.

19. July 3 1947 (Date rec'd by registrar) Whitney R. Frantz M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 1 1947, at 4-15 A M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from May 1947 to July 1 1947 and that I last saw h.. alive on July 1 1947

Immediate cause of death	DURATION
Chronic Cardio-Vascular Renal Disease	16 yrs
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Wm A Lopper md M. D., or other

Address: Hyndman Pa Date signed: 7/2/47

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 516

CERTIFICATE OF DEATH

05638

Reg. Dist. No. 4

1. PLACE OF DEATH:
County: Allegany
City or town: ~~Barton~~ Cumberland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 5 days
Hospital, Institution, or street address where death occurred: Allegany Hospital
How long in hospital or institution? 5 Days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md County: Allegany
City or town: Barton
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: Russell Kiddy, Sr.

3.(b) Social Security Number: ~~Not~~ 164-03-9023

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Lavinia Johnson Kiddy
6.(c) If alive, give age ..... years
7. Birth date of deceased (mo., day, yr.): October 29 1877

8. AGE: Years	Months	Days	If less than one day
69	8	29	..... hrs. ..... min.

9. Birthplace: Allegany Co. Maryland
(Town, County, and state)
10. Usual occupation: Miner - Retired and Janitor
11. Industry or business: Mines Bakery
FATHER 12. Name: Henry Kiddy
13. Birthplace: Unknown
MOTHER 14. Maiden name: Unknown
15. Birthplace: "
16. Informant: Russell Kiddy, Jr.
Address: Barton, Md
17. Burial (Burial, cremation, or removal. Which?) Date thereof July 31 1947 (month) (day) (year)
Cemetery or crematory: Laurel Hill Cem
Location: Maryland Md
18. Funeral director: Ellsworth & Bond
Address: Westernport
19. July 28, 1947 (Date rec'd by registrar) Winter R. Lantz, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 28 19 47 at 12 35 P.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 13 19 47 to July 28 19 47
and that I last saw h.. alive on July 28 19 47

Immediate cause of death	DURATION
(a) Coronary occlusion	Few Minutes
Due to:	
Due to:	
Other conditions: (a) Cancer of Prostate	2 yrs

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of .....
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE: P. V. Trenaka M.D.
M. D. or other
Address: Cumberland, Md Date signed 7/28/47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

Outside of City Limits

MARYLAND STATE DEPARTMENT OF HEALTH
2411 N. Charles St., Baltimore 46 e

05689

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:
County: Allegany
City or town: Near Cumberland, Rural
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 10 Years
Hospital, institution, or street address where death occurred: Woodlawn, LaVale, R.F.D. #1
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Allegany
City or town: Near Cumberland, Rural
(If outside city or town limits, write RURAL and give nearest town)
Street No.: Woodlawn, LaVale, R.F.D. #1
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: Rosalie Kifer

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband or wife: McClellan Kifer
6.(c) If alive, give age: 57 years

7. Birth date of deceased (mo., day, yr.): June 10, 1901

8. AGE: Years	Months	Days	If less than one day
46	1	11	....hrs. ....min.

9. Birthplace: Oldtown, Allegany Co., Maryland (Town, county, and state)
10. Usual occupation: Housewife
11. Industry or business: "

FATHER
12. Name: Wasson O. Myers
13. Birthplace: Penna

MOTHER
14. Maiden name: Elsie Starliper
15. Birthplace: Penna

16. Informant: Mr. McClellan Kifer
Address: La Vale, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof July 23, 1947 (month) (day) (year)
Cemetery or crematory: Glendale Cemetery
Location: Flintstone, Maryland

18. Funeral director: William H. Kight
Address: Cumberland, Md.

19. July 23, 1947 (Date rec'd by registrar) Walter R. Frantz, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 21 1947, at 6 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 1946 to July 21 1947 and that I last saw her alive on July 17 1947

Immediate cause of death: Carcinoma of Intestines — DURATION

Due to:

Due to:

Other conditions:

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Charlotte B. Gardner M.D. (M. D. or other)
Address: Cumberland, Md. Date signed 7/21/47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. (Incorrect age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

Within corporate limits: ✓

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 518

CERTIFICATE OF DEATH

05640

Reg. Dist. No. 4

1. PLACE OF DEATH:
County: Allegany
City or town: Cumberland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occurred:
203 Paca St.,
How long in hospitel or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Allegany
City or town: Cumberland
(If outside city or town limits, write RURAL and give neareat town)
Street No. 203 Paca St.,
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: James Albert Kight

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Widowed

6.(b) Name of husbend or wife: Josephine Troutman
6.(c) If alive, give age ..... years

7. Birth dete of deceased (mo., day, yr.): July 31, 1873

8. AGE: Years	Months	Days	If less than one day
73	11	~~15~~	..... hrs. ..... min.

9. Birthplace: Westernport, Md.
(Towu, county, and state)
10. Usual occupetion: Boiler Maker - Retired
11. Industry or buelnese: B.&O. Railroad
FATHER 12. Name: James P. Kight
13. Birthplace: Maryland
MOTHER 14. Maiden name: Sarah Price
15. Birthplace: Maryland
16. Informant: Mrs. Louis T. Helman
Address: 742 Gephart Drive Cumberland, Md.
17. Burial (Burial, eremation, or removal. Which?) Date thereof July 18, 1947 (month) (day) (year)
Cemetery or crematory: Philos Cem.
Location: Westernport, Md.
18. Funeral director: Charles L. George
Address: Cumberland, Md.
19. July 18, 1947 (Date rec'd by registrar) Walter L. Trauk M.D. Registrar

MEDICAL CERTIFICATION A.M.

20. DATE OF DEATH July 16, 1947 at 12:25

21. I CERTIFY that death occurred on the dete above stated; that I attended deceaced from May 19 1947, to July 16 1947
and that I last saw h.im alive on July 12 1947

Immediate cause of death	DURATION
Carcinoma of prostate	1 year
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op. .....
Autopsy results .....
PHYSICIAN: Please underline the cause to which death should he charged statistically.

22. VIOLENCE: If deeth was due to external ceuses, fill in the following:
Accident, suicide, or homicide ..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured et home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE P. H. Trenaski Jr. M.D. M. D. or Other
Address Cumberland, Md Date signed July 17-47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M


JUL 22 1907
SUKKUR C.B.

Within corporate limits

DR. R. Williams

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

638

CERTIFICATE OF DEATH

05641

Reg. Dist. No. 4

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:

County ALLEGANY

City or town CUMBERLAND, MARYLAND (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? ~~Memorial Hospital~~

Hospital, institution, or street address where death occurred: Memorial Hospital

How long in hospital or institution? 20 DAYS

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State MARYLAND County ALLEGANY

City or town ~~FROSTBURG~~ Ocean (If outside city or town limits, write RURAL and give nearest town)

Street No. R.F.D. #1 (If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME TIMOTHY KILDUFF

3.(b) Social Security Number 214-01-3734

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
MALE	WHITE	MARRIED

6.(b) Name of husband or wife MARGARET LENNAN 6.(c) If alive, give age 59 years

7. Birth date of deceased (mo., day, yr.) June 9, 1888

8. AGE: Years	Months	Days	If less than one day
58 ~~58~~	1	10	hrs. min.

9. Birthplace Westernport, Alleg. Co., Md. (Town, county, and state)

10. Usual occupation Clerk and Clerk Weighman

11. Industry or business Consolidation Coal and Fuel Co.

FATHER 12. Name PATRICK KILDUFF

13. Birthplace Ireland

MOTHER 14. Maiden name MARY WHITE

15. Birthplace Ireland

16. Informant Thos. Kilduff

Address Ocean, Md.

17. Burial (Burial, cremation, or removal Which?) Date thereof July 22, 1947 (month) (day) (year)

Cemetery or crematory St. Peter Cem.

Location Westernport, Md.

18. Funeral director W. Eschelman

Address Lonaconing Md.

19. July 21, 1947 (Date rec'd by registrar) Wister R. Frantz M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH JULY 19, 1947 19... at 1:43 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 15 19 47 to July 19 19 47

and that I last saw him alive on July 19 19 47

Immediate cause of death	DURATION
Myocardial Failure	3 days
Due to Hypertension	3 yrs.
Due to 13b	
Other conditions	

(Incinde pregnancy within 3 months of death)

Major findiogs of operations Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE [signature] M.D. M. D. or other

Address [illegible] Date signed 7/24/47


RECEIVED
JUL 29 1947
BUREAU OF

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 94a

CERTIFICATE OF DEATH

05635

B

Reg. Dist. No. 4

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:

County Allegany

City or town Cumberland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 1 yrs

Hospital, Institution, or street address where death occurred:

827 Virginia Ave.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State W. Va. County Morgan

City or town Sir Johns Run

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Lawrence S. Kiplinger

3.(b) Social Security Number ?

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Widowed

6.(b) Name of husband or wife Ida Miller

6.(c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) September 18, 1882

8. AGE: Years	Months	Days	If less than one day
64	10	8	...hrs. ...min.

9. Birthplace Martinsburg W. Va.
(Town, county, and state)

10. Usual occupation Retired Steam Shovel Operator

11. Industry or business

FATHER 12. Name David R. Kiplinger

13. Birthplace Keedysville Md.

MOTHER 14. Maiden name Mary A. Martin

15. Birthplace Front Royal, Va.

16. Informant R. L. Kiplinger

Address Martinsburg W Va.

17. Burial (Burial, cremation, or removal. Which?) Date thereof July 29 47 (month) (day) (year)

Cemetery or crematory Green Hill Cem.

Location Martinsburg W. Va.

18. Funeral director Kogelschatz & Coffman

Address Martinsburg W. Va.

19. July 28, 1947 (Date rec'd by registrar) Walter R. Haught M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 26, 1947 at 3:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 4, 1947, to July 26, 1947 and that I last saw h... alive on July 26, 1947

Immediate cause of death	DURATION
Coronary occlusion	1/2 hr
Due to Arterio Sclerosis	3 yrs
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide No Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE M E B Lewis M.D.

M. D. or other

Address 133 Va Ave Date signed 7/26/47

Within corporate limits.

Dr. Fauver

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 186a

05642

CERTIFICATE OF DEATH

Reg. Dist. No. 4

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:

County: Allegany

City or town: Cumberland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 35 years

Hospital, institution, or street address where death occurred: Allegany Hospital

How long in hospital or institution? 1 week

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Allegany

City or town: Cumberland

(If outside city or town limits, write RURAL and give nearest town)

Street No. 29 Browning St

(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: Bessie Belle Kirby

3.(b) Social Security Number: 217-10-5839

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	Single

6.(b) Name of husband or wife:

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): June 6, 1887

8. AGE: Years	Months	Days	If less than one day
60	0	29	hrs. min.

9. Birthplace: Longacoming, Allegany, Md. (Town, county, and state)

10. Usual occupation: Textile worker

11. Industry or business: C. C. of A.

FATHER

12. Name: John Randolph Kirby

13. Birthplace: Longacoming, Md

MOTHER

14. Maiden name: Hannah Arbogast

15. Birthplace: Longacoming, Md.

16. Informant: Mrs. Mary Carter

Address: Wheeling, W. Va.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: July 8, 1947 (month) (day) (year)

Cemetery or crematory: Rose Hill Cemetery

Location: Cumberland, Md.

18. Funeral director: John J. Hafer

Address: Cumberland, Md.

19. July 8 1947 (Date rec'd by registrar) Walter R. Frantz, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 5 1947, at 12:10 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 24 1947, to July 5 1947

and that I last saw h[illegible] alive on July 5 1947

Immediate cause of death: Fracture Right Hip. — DURATION: June 24 1947

Due to: Fall - at home

Due to:

Other conditions: Myocardial decompensation

(Include pregnancy within 3 months of death)

Major findings of operations: None

Date of op.:

Autopsy results: None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Accident Date of: June 24, 1947

Where did injury occur? Cumberland (City or town) Allegany (County) Md. (State)

Injured at home, farm, industry, public place (where?): at Home

Means of injury: fell in kitchen Injured at work?

23. SIGNATURE: Walter R Frantz Jr. M. D. or other

Address: Cumberland, Md. Date signed: July 6, 1947


RECEIVED
JUL 15 1947

Within corporate limits

Reference for the change of age and birthdate is shown on G 112 9/15/47 DR. R. WILLIAMS

05643

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 97

CERTIFICATE OF DEATH

B Reg. Dist. No. 4

1. PLACE OF DEATH:
County ALLEGANY
City or town CUMBERLAND
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 4 MONTHS 23 DAYS
Hospital, institution, or street address where death occurred:
MEMORIAL HOSPITAL
How long in hospital or institution? 4 MONTHS 23 DAYS

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State WEST VIRGINIA County Morgan
City or town PAW PAW
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME MR. NELSON LANCASTER

3.(b) Social Security Number Unable to Locate

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
MALE	WHITE	MARRIED

6.(b) Name of husband or wife EMILY BANE
6.(c) If alive, give age 64 years

7. Birth date of deceased (mo., day, yr.) NOVEMBER 4, ~~1875~~ 1874

8. AGE: Years	Months	Days	If less than one day
72 ~~73~~	8	6	hrs. min.

9. Birthplace MARYLAND (Town, county, and state)
10. Usual occupation Labor
11. Industry or business ~~Baltimore~~ Western Md. & ~~Ohio~~ Railroad

FATHER
12. Name ANDREW LANCASTER
13. Birthplace MARYLAND

MOTHER
14. Maiden name CHARLOTTE WINTERS
15. Birthplace MARYLAND

16. Informant MEMORIAL HOSPITAL
Address CUMBERLAND, MARYLAND

17. Burial (Burial, cremation, or removal. Which?) Date thereof 7/13/47 (month) (day) (year)
Cemetery or crematory Camp Hill Cemetery
Location Paw Paw, W. Va.
18. Funeral director W. D. Parks
Address Berkeley Springs, W. Va.

19. July 11, 1947 (Date rec'd by registrar) Winty R. Frantz, M.D. Acting Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH JULY 10, 1947, at 7:10P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 25 1947 to July 10 1947 and that I last saw h[illegible] alive on 7/10/47 1947

Immediate cause of death	DURATION
Chr Uremia	10yr
Due to Arteriosclerosis	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

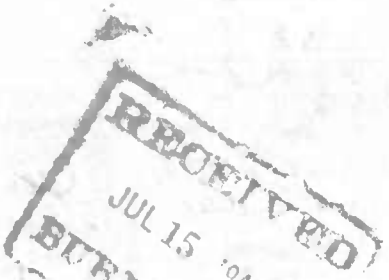
22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE C. D. Williams M.D. M.O. or other
Address Medical Clinic Date signed 7/11/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Use correct age if known. Information is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M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JUL 15 1947
BURT

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

168

CERTIFICATE OF DEATH

05649

Reg. Dist. No. 9

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:

County: Allegany

City or town: Frostburg Md.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 3.1/2 hrs

Hospital, institution, or street address where death occurred:
Miners Hospital Frostburg Md.

How long in hospital or institution? 3.1/2 Hours

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Md. County: Garrett

City or town: (Rural) Star Route, Frostburg Md.
(If outside city or town limits, write RURAL and give nearest town)

Street No. ✓
(If rural, give LOCATION)

2.(a) If veteran, name war: World War 1

3.(a) FULL NAME

Elzie F. Layman

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	single

6.(b) Name of husband or wife:

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Feb. 7 1898

8. AGE: Years	Months	Days	If less than one day
49			hrs. min.

9. Birthplace: Avilton Md.
(Town, county, and state)

10. Usual occupation: farmer

11. Industry or business

FATHER — 12. Name: Louis H. Layman

13. Birthplace: Avilton Md.

MOTHER — 14. Maiden name: Minnie Dorsey

15. Birthplace: Avilton Md.

16. Informant: Mother - Mrs. Louis Layman

Address: Star Rt. Frostburg, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 8-4-47 (month) (day) (year)

Cemetery or crematory: St. Annes Cemetery

Location: Avilton, Md.

18. Funeral director: Wm. Wintsberg

Address: Grantsville, Md.

19. 7-31 1947 (Date rec'd by registrar) Mrs. Harry N. Roe Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 31 1947, at 3.35 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..., to ..... 19...

and that I last saw him alive on Dead July 31 1947

Immediate cause of death — DURATION

Pulmonary hemorrhage & fractured ribs, left side of chest. — 4 hours

Due to:

Due to: Hit & run driver: Premeditated. Ran him down on purpose. 9/8/47 as

Other conditions: Fractured left scapulae large laceration of back & scalp
(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Homicide Accident Date of: 7.30.47

Where did injury occur? route 40 3 miles west of Frostburg (City or town) Garrett (County) Md. (State)

Injured at home, farm, industry, public place (where?): route 40 near Happy Hill Farm, Garrett Co.

Means of injury: Hit & run driver Injured at work? no

Deputy Medical Examiner - Allegany Co.

23. SIGNATURE: H.V. Deming M.D. H.V. Deming MD (M. D. or other)

Address: Cumberland, Md. Date signed: 7-31-47

See Permanent File under Deming - 9/4/47.

Within corporate limits

Schindler Hafer

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 93d

CERTIFICATE OF DEATH

05645

Reg. Dist. No. 4

1. PLACE OF DEATH:

County Allegany

City or town Cumberland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 15 years

Hospital, institution, or street address where death occurred:
Allegany Hospital

How long in hospital or institution? 3 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Md County Allegany

City or town Cumberland
(If outside city or town limits, write RURAL and give nearest town)

Street No. 316 Cecelia St.
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME Ella Lee

3. (b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	Married

6.(b) Name of husband or wife Clayton Lee

6.(c) If alive, give age 77 years

7. Birth date of deceased (mo., day, yr.) July 23, 1877

8. AGE: Years	Months	Days	If less than one day
69	11	18	hrs. min.

9. Birthplace Chaneysville, Pa.
(Town, county, and state)

10. Usual occupation Housewife

11. Industry or business Own home

FATHER
12. Name Hezekiah Walters
13. Birthplace Pa.

MOTHER
14. Maiden name Rachel A. Wilkinson
15. Birthplace Pa.

16. Informant Mrs. Sherman Keel
Address 30 Orchard St. Cumberland

17. Burial (Burial, cremation, or removal. Which?) Date thereof July 13, 1947 (month) (day) (year)

Cemetery or crematory Chaneysville Methodist Cemetery

Location Chaneysville, Pa.

18. Funeral director John J. Hafer

Address Cumberland, Md.

19. July 12, 1947 (Date rec'd by registrar) Witter Pitranty, M.D. Acting Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH (Mo.) July 11 19 47 at 9:55 A. M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from July 6 1947 to July 11 1947 and that I last saw her alive on July 11 1947

Immediate cause of death Hypertension C.V.D. Uremia — DURATION: years

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

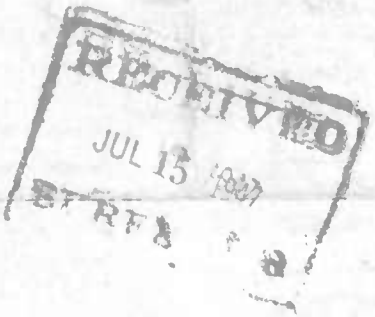
23. SIGNATURE B. M. Schmucker M. D. or other

Address 41 Ernest Date signed July 12/1947

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M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JUL 15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 93a

CERTIFICATE OF DEATH

05646

Reg. Diat. No. 1

1. PLACE OF DEATH:
County Allegany
City or town Rural - Hancock
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? Life
Hospital, Institution, or street address where death occurred:
Little Orleans, Md.
How long in hospital or institution? —

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Allegany
City or town Rural - Hancock
(If outside city or town limits, write RURAL and give nearest town)
Street No. Piney Plains
(If rural, give LOCATION)
2.(a) If veteran, name war —

3.(a) FULL NAME Theodore Thomas Mann

3.(b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of ~~husband or~~ wife Maude Elmira Price Mann 6.(c) If alive, give age 59 years

7. Birth date of deceased (mo., day, yr.) March 11, 1874

8. AGE: Years 73 | Months 4 | Days 3 | If less than one day — hrs. — min.

9. Birthplace Allegany Co., Maryland (Town, county and state)

10. Usual occupation Retired School Teacher

11. Industry or business Asst Deputy Local Registrar

FATHER
12. Name Henry Mann
13. Birthplace Pennsylvania

MOTHER
14. Maiden name Margaret Foster
15. Birthplace Pennsylvania

16. Informant Mrs. T. T. Mann
Address Little Orleans, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof July 17, 1947 (month) (day) (year)
Cemetery or crematory Piney Plains Meth. Church
Location Piney Plains, Allegany Co., Md.

18. Funeral director Charles R. Bast
Address Hancock, Md.

19. July 15 1947 (Date rec'd by registrar) Mrs C.A. Shanholtz Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 14, 1947 at 6 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from — 1934 to July 14 1947
and that I last saw him alive on July 14, 1947

Immediate cause of death	DURATION
Acute myocarditis	2 weeks
Due to	
Due to	
Other conditions arthritis deformans	13 yrs.

(Include pregnancy within 3 months of death)

Major findings of operation — Date of op. —

Autopsy results —

PHYSICIAN: Please underline the cause to which death should be charged statistically.

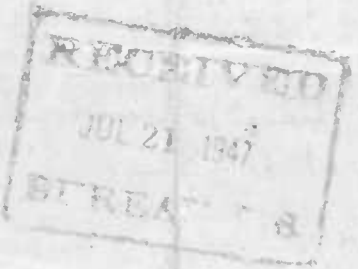
22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide — Date of —
Where did injury occur? — (City or town) — (County) — (State)
Injured at home, farm, industry, public place (where?) —
Means of injury — Injured at work? —

23. SIGNATURE J. A. Watson, M.D. (M. D. or other)
Address Little Orleans Md. Date signed 7/15/47

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING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JUL 21 1947

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 93d

CERTIFICATE OF DEATH

Reg. Dist. No. 05647

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:
County: Allegany
City or town: Westernport
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 55 Yrs
Hospital, institution, or street address where death occurred: 224 Wood St
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Allegany
City or town: Westernport
(If outside city or town limits, write RURAL and give nearest town)
Street No. 224 Wood St.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: Henry Washington Matthews

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Susan Mathews
6.(c) If alive, give age: 86 years

7. Birth date of deceased (mo., day, yr.): Dec. 19, 1859

8. AGE: Years	Months	Days	If less than one day
87	7	4	...hrs. ...min.

9. Birthplace: Midland-Allegany-Md. (Town, county, and state)
10. Usual occupation: Carpenter-Foreman
11. Industry or business: Rail-Road

FATHER
12. Name: Henry Mathews
13. Birthplace: Not Known

MOTHER
14. Maiden name: Mary Sashbaugh
15. Birthplace: Not Known

16. Informant: Harry Mathews
Address: Keyser, W.Va.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: July 25, 47 (month) (day) (year)
Cemetery or crematory: Philos Cem.
Location: Westernport, Md.

18. Funeral director: Ellsworth S. Boal
Address: Westernport, Md.

19. July 25 1947 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 23 1947, at 10.30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept 2 1946, to July 23 1947
and that I last saw h.. alive on July 23 1947

	DURATION
Immediate cause of death: Acute Edema of lungs	1 Day
Due to: Chronic Myocarditis and Myocardial Degeneration not Specified as rheumatic	1 Year
Other conditions: Hypertrophy of Prostate	15 Years

(Include pregnancy within 3 months of death)

Major findings of operations: None
Date of op.
Autopsy results: None
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following: None
Accident, suicide, or homicide. Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE: Paul B. Wilson, M.D.
M. D. or other
Address: Piedmont, W.Va. Date signed: July 25, 1947

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 93d

CERTIFICATE OF DEATH

05648

Reg. Dist. No. 4

1. PLACE OF DEATH:

County Allegany

City or town Cumberland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 24 years

Hospital, Institution, or street address where death occurred: 507 Baltimore Avenue

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County Allegany

City or town Cumberland

(If outside city or town limits, write RURAL and give nearest town)

Street No. 507 Baltimore Ave.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Elizabeth Ann Mattingly

3.(b) Social Security Number None

4. Sex: Female

5. Color or race: White

6.(a) Single, married, widowed, or divorced: Widowed

6.(b) Name of husband or wife: Bernard Mattingly

6.(c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr.): Nov. 19th. 1869

8. AGE: Years 77 | Months 7 | Days 20 | If less than one day ____ hrs. ____ min

9. Birthplace: Cumberland Alley, Md (Town, county, and state)

10. Usual occupation: Housework

11. Industry or business

FATHER

12. Name: George Rudel

13. Birthplace: Germany

MOTHER

14. Maiden name: Margaret Kolb

15. Birthplace: Cumberland, Md.

16. Informant: Mrs. Ashlyn Dias

Address: 507 Baltimore Ave Cumberland Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof July 12-1947 (month) (day) (year)

Cemetery or crematory: St. Patricks Cemetery

Location: Cumberland, Md.

18. Funeral director: Daniel D. Kelly

Address: Flintstone, Md.

19. July 10, 1947 (Date rec'd by registrar) Winter R. Frantz, M.D. Acting Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 9 1947, at 4 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 2 1947 to July 9 1947 and that I last saw her alive on July 9 1947

Immediate cause of death: myocarditis — DURATION: 3 yrs.

Due to: chronic arthritis and — 5 yrs.

Due to:

Other conditions:

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: No Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, Industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE M.E.B. Owens M. D. or other

Address 133 Seventh ave. Date signed 7/10/47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M


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JUL 15
BUREAU

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 83C

CERTIFICATE OF DEATH

05649

Reg. Dist. No. 6

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:

County: Allegany

City or town: Barton (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 79 Yrs.

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: Md. County: Allegany

City or town: Barton (If outside city or town limits, write RURAL and give nearest town)

Street No. (If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: Mary Jane McDonald

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widow

6.(b) Name of husband or wife: John James McDonald

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Aug. 15, 1867

8. AGE: Years	Months	Days	If less than one day
79	11	7	..... hrs. ..... min.

9. Birthplace: Barton-Allegany-Md. (Town, county, and state)

10. Usual occupation: House-work

11. Industry or business: Own-Home

FATHER 12. Name: Henry Miller

FATHER 13. Birthplace: Lonaconing, Md.

MOTHER 14. Maiden name: Dorcas Duckworth

MOTHER 15. Birthplace: Barton, Md.

16. Informant: Harry McDonald

Address: Towson, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof July 24, 47 (month) (day) (year)

Cemetery or crematory: Philos

Location: Westernport, Md.

18. Funeral director: Ellsworth S. Boal

Address: Westernport, Md.

19. July 24 1947 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 22 19 47 at 7.30A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 1, 1947 to July 22, 1947 and that I last saw him alive on July 22 1947

Immediate cause of death	DURATION
Cerebral thrombosis	6 mo.
Due to Cerebral Arteriosclerosis	6 mo.
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Thomas Reece M.D. M. D. or other

Address: Westernport Md. Date signed: 7-23-47

Outside City Limits

Richard Williams

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 1318

CERTIFICATE OF DEATH

Reg. Dist. No. 05630 4

M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:

County Allegany

City or town Near Cumberland, Rural

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 51 years

Hospital, Institution, or street address where death occurred: Rt. 3, Bedford Road, Md

How long in hospital or Institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Allegany

City or town Near Cumberland, Rural

(If outside city or town limits, write RURAL and give nearest town)

Street No. Route 3, Bedford Road

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Hannah Belle McElfish

3.(b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	Widowed

6.(b) Name of husband or wife W. Frank McElfish

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) March 29, 1869

8. AGE: Years	Months	Days	If less than one day
78	3	8	..... hrs. ..... min.

9. Birthplace Bedford Co., Pa. (Town, county, and state)

10. Usual occupation Housewife

11. Industry or business Own home

FATHER 12. Name Amos Robinette

FATHER 13. Birthplace Bedford Co. Pa

MOTHER 14. Maiden name Rachael Dicken

MOTHER 15. Birthplace Bedford Co. Pa

16. Informant Vernon McElfish

Address Rt 2 Keyser W. Va.

17. Burial (Burial, cremation, or removal. Which?) Date thereof July 10 1947 (month) (day) (year)

Cemetery or crematory Zion Memorial Cemetery

Location Near Cumberland, Md.

18. Funeral director John J. Hafer

Address Cumberland Md.

19. July 10 1947 (Date rec'd by registrar) Wintes L. Frantz, M.D. Acting Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 7 1947 at 4:00 PM.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 1 1947 to July 7, 1947 and that I last saw h.. alive on 7/7/47 1947

Immediate cause of death Uremia — DURATION 5 days Coma

Due to Chr. Nephritis

Due to Arteriosclerosis

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op. .....

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work? .....

23. SIGNATURE R. W. Thompson M.D. M. D. of other

Address Cumberland Md. Date Signed 7/8/47

Mr Hyer

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 838

05651

CERTIFICATE OF DEATH

Reg. Dist. No. 4

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:

County: Allegany

City or town: Cumberland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 45 Years

Hospital, institution, or street address where death occurred:
Allegany Hospital

How long in hospital or institution? 5 Days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Allegany

City or town: Cumberland
(If outside city or town limits, write RURAL and give nearest town)

Street No. 107 Park Street
(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: Samuel G. Myers

3.(b) Social Security Number: 705-09-3627

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single

6.(b) Name of husband or wife:

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): July 11, 1884

8. AGE: Years	Months	Days	If less than one day
62	11	24	hrs. min.

9. Birthplace: Hancock, Washington Co. Maryland
(Town, county, and state)

10. Usual occupation: Brakeman

11. Industry or business: B. & O. Railroad

FATHER
12. Name: William Myers
13. Birthplace: Warfordsburg, Pa.

MOTHER
14. Maiden name: Anna May Baylor
15. Birthplace: Hancock, Md.

16. Informant: Miss Susan Myers
Address: 107 Park St. Cumberland, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof July 8, 1947 (month) (day) (year)

Cemetery or crematory: Dunkard Cemetery

Location: Hancock, Md.

18. Funeral director: William H. Kight

Address: Cumberland, Md.

19. July 7 1947 (Date rec'd by registrar) Whitney L. Trautz, M.D. acting Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 5 1947, at 12-01A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 29 1947 to July 5 1947 and that I last saw him alive on July 5 1947

Immediate cause of death: Hemiplegia, neglected

DURATION
7 days

Due to:

Due to:

Other conditions:

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: J. J. Johnson Jr. M.D. M. D. or Coroner

Address: Cumberland, Md. Date signed: 7-5-47

Outside of City Limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 1312

CERTIFICATE OF DEATH

05652

Reg. Dist. No. 4

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct name is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:

County: Allegany

City or town: Rural - Cumberland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred: Locust Grove

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Allegany

City or town: Rural Cumberland

(If outside city or town limits, write RURAL and give nearest town)

Street No. Locust Grove

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: David Chester Peck

3.(b) Social Security Number: 217-10-6268

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Agnes J Johnelson

6.(c) If alive, give age: ..... years

7. Birth date of deceased (mo., day, yr.): Aug 7, 1872

8. AGE: Years: 74 | Months: 11 | Days: 4 | If less than one day: ..... hrs. ..... min.

9. Birthplace: Everett Pa.

(Town, county, and state)

10. Usual occupation: Machinist

11. Industry or business: Celanese Corp.

FATHER 12. Name: Llewlyn Peck

FATHER 13. Birthplace: Pa.

MOTHER 14. Maiden name: Margaret Amich

MOTHER 15. Birthplace: Pa.

16. Informant: Mrs. A. Jane Peck

Address: Locust Grove Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: July 14, 47 (month) (day) (year)

Cemetery or crematory: Rose Hill Cem

Location: Cumberland Md.

18. Funeral director: Louis Stein Inc.

Address: Cumberland Md

19. July 14, 1947 (Date rec'd by registrar) Witness R. Lantz M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 11, 1947, at 11 33 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 10, 1947, to July 11, 1947 and that I last saw him alive on June 10, 1947

	DURATION
Immediate cause of death: Uremia Cardiac	3 days
Due to:	
Due to:	
Other conditions: Chronic Nephritis	—

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: A. W. Swayden M. D. or other

Address: Cumberland Md Date signed: 7-14-47

Mr Snyder
Please sign This
And place it on
The outside office

Withdraw report if unable

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 164c

CERTIFICATE OF DEATH

05653

Reg. Dist. No. 4

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:

County Allegany

City or town Cumberland Md.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 63-8-23

Hospital, institution, or street address where death occurred:
421 Independence St

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Md. County Allegany

City or town Cumberland
(If outside city or town limits, write RURAL and give nearest town)

Street No. 421 Independence St.
(If rural, give LOCATION)

2.(a) If veteran, name war World War I

3.(a) FULL NAME Tolbert Raymond Peterman

3.(b) Social Security Number 714-05-6650

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	married

6.(b) Name of husband or wife Anna Eppler Peterman

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Oct. 14- 1883

8. AGE: Years	Months	Days	If less than one day
63	8	23	..... hrs. ..... min.

9. Birthplace Cumberland Md.
(Town, county, and state)

10. Usual occupation Linotype operator

11. Industry or business News paper

FATHER 12. Name Tolbert G Peterman

13. Birthplace Md

MOTHER 14. Maiden name Mary Miller

15. Birthplace Md.

16. Informant Wm. Peterman

Address Los Angeles, Cal.

17. Burial (Burial, cremation, or removal. Which?) Date thereof July 10 '47 (month) (day) (year)

Cemetery or crematory St Lukes Cem.

Location Cumberland

18. Funeral director Louis Stein Inc

Address Cumberland

19. July 10, 1947 (Date rec'd by registrar) Witter R Krantz M.D. acting Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 7, 1947, at 12.30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....

and that I last saw him alive on July 7, 1947

Immediate cause of death Pulmonary hemorrhage — DURATION: at once

Due to Shot himself with a 38 caliber revolver, left side of chest.

Due to Worry

Other conditions Illuminating gas & cut left wrist with a knife. Superficial
(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide suicide Date of 7-7-47

Where did injury occur? Cumberland (City or town) Allegany (County) Md. (State)

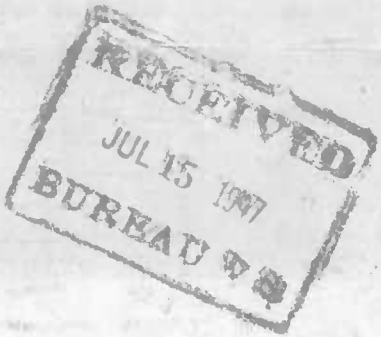
Injured at home, farm, industry, public place (where?) home (bedroom)

Means of injury as above Injured at work? no

Deputy Medical Examiner - Allegany Co

23. SIGNATURE H.V. Deming M.D. H.V. Deming M.D. M. D. or other

Address Cumberland Md. Date signed 7-7-47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BUREAU OF

Within corporate limits

DR. VAN ORMER

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 1312

CERTIFICATE OF DEATH

05654

Reg. Dist. No. 4

1. PLACE OF DEATH:
County ALLEGANY
City or town CUMBERLAND (If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 38 DAYS
Hospital, Institution, or street address where death occurred:
MEMORIAL HOSPITAL
How long in hospital or institution? 38 DAYS

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)
State MARYLAND County ALLEGANY
City or town ECKHART (If outside city or town limits, write RURAL and give nearest town)
Street No. Rt. 1, Frostburg (If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME CHARLES W. PHILLIPS

3.(b) Social Security Number 214-05-9864

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
MALE	WHITE	MARRIED

6.(b) Name of husband or wife MARY EISENTROUT PHILLIPS 6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) AUGUST 26, 1893

8. AGE: Years	Months	Days	If less than one day
53	10	22	..... hrs. ..... min.

9. Birthplace Eckhart, Allegany, Md. (Town, county, and state)
10. Usual occupation KELLY TIRE COMPANY
11. Industry or business

FATHER
12. Name THOMAS PHILLIPS
13. Birthplace MARYLAND Frostburg

MOTHER
14. Maiden name Catherine ~~SPITH~~ I. Nelson
15. Birthplace ~~ENGLAND~~ Eckhart, Md

16. Informant William H. Phillips
Address Eckhart, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof July 21, 1947 (month) (day) (year)
Cemetery or crematory Allegany Cemetery
Location Frostburg, Md.
18. Funeral director Jacob Hoffman
Address Frostburg, Maryland.
19. July 19, 1947 (Date rec'd by registrar) Walter R. Grant, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 18, 1947, at 7:50 P.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from July 7, 1947, to July 18, 1947 and that I last saw h[illegible] alive on July 18, 1947

Immediate cause of death	DURATION
Uremic Poisoning	10 wks.
Due to Chronic Nephritis	1½ yrs.
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op. .....
Autopsy results .....
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE Arthur F. Jones M.D. M. D. or other
Address 110 S. Centre St. Date signed 7-19-47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M


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MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 468

CERTIFICATE OF DEATH

05655

Reg. Dist. No. 9

1. PLACE OF DEATH:

County Allegany

City or town New Shaft Maryland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 45 yrs

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md County Allegany

City or town New Shaft

(If outside city or town limits, write RURAL and give nearest town)

Street No. R.D. No 1 Box 83 Frostburg, Md.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Effie Frances Plummer

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Single

6.(b) Name of husband or wife

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Sept 18th, 1888

8. AGE: Years	Months	Days	If less than one day
58	9	29	..... hrs. ..... min.

9. Birthplace New Shaft Allegany, Md.

(Town, county, and state)

10. Usual occupation House Work

11. Industry or business

FATHER 12. Name David H. Plummer

13. Birthplace Claysville, Md.

MOTHER 14. Maiden name Caroline Seton

15. Birthplace Old Town, Md.

16. Informant Oscar Plummer

Address R.D. #1 Box 83, Frostburg Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 7/19/1947 (month) (day) (year)

Cemetery or crematory Allegany Cemetery

Location Frostburg, Md.

18. Funeral director Jacob A. Yaker

Address Frostburg, Maryland.

19. 7-19 (Date rec'd by registrar) 19 47 Mrs. Nancy V. Roe Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 17 1947, at 1.45 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 3-28 1947, to 7-15 1947 and that I last saw her alive on 7-15 1947

Immediate cause of death	DURATION
Carcinoma of Common Duct & Metastases	8 mos
Jaundice	4 mos.
Due to Cholecystitis (chr) & cholelithiasis	20 yrs.
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations Carcinoma of Common duct & met. to liver. Thickened G.B. & Stone Date of op. 4/24/47

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE Frank T. Harret M.D. M. D. or other

Address 59 E. Main St. Frostburg Date signed 7/19/47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

Within corporate l...

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

05656

Reg. Dist. No. 4

1. PLACE OF DEATH:
County: Allegany
City or town: Cumberland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 4 days
Hospital, Institution, or street address where death occurred: Allegany Hospital
How long in hospital or institution? 4 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Allegany
City or town: Barrellville
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: Darlene Mae Porter

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Single

6.(b) Name of husband or wife

6.(c) If alive, give age ... years

7. Birth date of deceased (mo., day, yr.): Dec. 5, 1946

8. AGE: Years	Months	Days	If less than one day
0	7	9	...hrs. ...min.

9. Birthplace: Cumberland, Md. (Town, county, and state)

10. Usual occupation

11. Industry or business

FATHER
12. Name: Elthea Porter
13. Birthplace: Penna

MOTHER
14. Maiden name: James Scell
15. Birthplace: Penna

16. Informant: Mrs. Elthea Porter
Address: Barrellville, Md.

17. (Burial, cremation, or removal. Which?) Burial Date thereof 7/19/47 (month) (day) (year)
Cemetery or crematory: xxxx White Oak
Location: Somerset Co,., Pa.

18. Funeral director: Harvey H. Zeigler
Address: Hyndman, Pa.

19. (Date rec'd by registrar) July 18, 1947 Walter L. Faulk, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 16th 1947 at 8:15 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 6th 1947 to July 16 1947 and that I last saw h.. alive on July 16 1947

Immediate cause of death	DURATION
Lobar Pneumonia	
Due to	
Due to	
Other conditions Empyema -	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE: William E. Moseley M. D. or other
Address: McDonough Md Date signed 7-18-1947

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15


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MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

1170

05857

Reg. Diat. No. 9

1. PLACE OF DEATH:

County: Allegany

City or town: Frostburg

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 2 days

Hospital, Institution, or street address where death occurred: Miners Hospital

How long in Hospital or Institution? 1 day

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md. County: Allegany

City or town: Zihlman

(If outside city or town limits, write RURAL and give nearest town)

Street No. R. D. No. 2 Frostburg, Md.

(If rural, give LOCATION)

2.(a) If veteran, name war:

3. (a) FULL NAME: Alfred Pyzer, Sr

3. (b) Social Security Number: 219-03-9942

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Lucy Pope Pyzer

6.(c) If alive, give age: 69 years

7. Birth date of deceased (mo., day, yr.): July 4th, 1869

8. AGE: Years: 78 | Months: 7 | Days: 24 | If less than one day: hrs. min.

9. Birthplace: Frostburg, Allegany Md.

(Town, county, and state)

10. Usual occupation: Laborer

11. Industry or business: Brick Co.

FATHER — 12. Name: Lemuel Pyzer

FATHER — 13. Birthplace: Pyrmont, Pa.

MOTHER — 14. Maiden name: Henrietta Pickering

MOTHER — 15. Birthplace: Mt. Savage, Md.

16. Informant: Lucy Pyzer

Address: Zihlman R.D. #2 Frostburg

17. Burial (Burial, cremation, or removal. Which?) Date thereof: 7-31-1947 (month) (day) (year)

Cemetery or crematory: Allegany Cemetery

Location: Frostburg, Md.

18. Funeral director: Jacob Baker

Address: Frostburg, Md.

19. 7-30 1947 (Date rec'd by registrar) Mrs. Nancy N. Rae Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 28 1947, at 1.45 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 27 1947 to July 28 1947 and that I last saw him alive on July 28, 1947

Immediate cause of death	DURATION
Shock	2 hrs
Due to: Gastric Hemorrhage (Interpatient)	24 hrs, 45
Due to: Perforated Peptic ulcer	
Other conditions: Benign Hypertrophy of prostate & prostatitis, atony of bladder	3 yrs.

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: Frank T. Harral M.D. M. D. or other

Address: 59 E. Main St. Frostburg, Md. Date signed: 7/29/47

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 468

CERTIFICATE OF DEATH

05658

Reg. Dist. No. 6

1. PLACE OF DEATH:

County: Allegany

City or town: Westernport - rural
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 50 years

Hospital, Institution, or street address where death occurred:
1 mi no of Westernport

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Allegany

City or town: Westernport - rural
(If outside city or town limits, write RURAL and give nearest town)

Street No. 1 mi no of Westernport
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME: Jane Rollins

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	~~M~~ Single

6.(b) Name of husband or wife:

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): January 25, 1866

8. AGE: Years	Months	Days	If less than one day
81	5	14	..... hrs. ..... min.

9. Birthplace: Scotland
(Town, county, and state)

10. Usual occupation: Domestic

11. Industry or business: Own home

FATHER
12. Name: John C. Rollins
13. Birthplace: Ireland

MOTHER
14. Maiden name: Margaret Weir
15. Birthplace: Scotland

16. Informant: John Rollins, Sr.
Address: Westernport, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof July 11, 1947 (month) (day) (year)

Cemetery or crematory: Philos cemetery

Location: Westernport, Maryland

18. Funeral director: Ellsworth C. Doal

Address: Westernport, Maryland

19. July 11 1947 [illegible] Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 9, 1947, at 9:30a M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 25 1947, to July 9 1947
and that I last saw her alive on July 8 1947

Immediate cause of death: Carcinoma of liver with General Metastasis — DURATION: 3 Months

Due to:

Due to:

Other conditions:

(Include pregnancy within 3 months of death)

Major findings of operations: None — Date of op.

Autopsy results: None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following: None

Accident, suicide, or homicide — Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury — Injured at work?

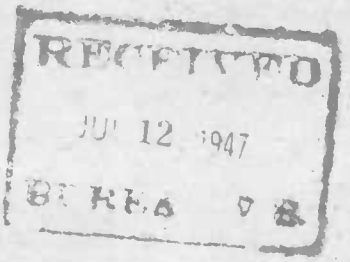
23. SIGNATURE: Paul D Watson M D
M. D. or other

Address: Piedmont, W. Va — Date signed: July 10, 1947

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Use correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING


RECEIVED
JUL 12 1947

Within [illegible] Whitworth. 2H 8

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 160C

05653

CERTIFICATE OF DEATH

Reg. Diat. No. 4

1. PLACE OF DEATH:

County ALLEGANY

City or town CUMBERLAND
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 13 HOURS

Hospital, institution, or street address where death occurred:
MEMORIAL HOSPITAL

How long in hospital or institution? 13 HOURS

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State MARYLAND County ALLEGANY

City or town CUMBERLAND
(If outside city or town limits, write RURAL and give nearest town)

Street No. 420 AVERITT AVE
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME

RUNION BABY BOY

3.(b) Social Security Number

None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
MALE	WHITE	SINGLE

6.(b) Name of husband or wife

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) July 8, 1947

8. AGE: Years	Months	Days	If less than one day
			13 hrs. ..... mtn.

9. Birthplace memorial Cumberland, Md
(Town, county, and state)

10. Usual occupation Infant

11. Industry or business

FATHER
12. Name RUNION WILLIAM
13. Birthplace MARYLAND

MOTHER
14. Maiden name SHIMENOK GENEVIEVE
15. Birthplace MARYLAND

16. Informant William Runion
Address Cumberland, Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof July 9, 1947 (month) (day) (year)

Cemetery or crematory Ft Ashby Methodist Cemetery

Location Ft. Ashby, W. Va.

18. Funeral director John J. Hofer

Address Cumberland, Md.

19. July 9, 1947 (Date rec'd by registrar) Walter F. Frantz, M.D. acting Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 8 July 1947 at 1:40 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 8 July 1947 to 8 July 1947 and that I last saw him alive on 8 July 1947

Immediate cause of death	DURATION
Prematurity (1 mo)	
Due to	
Due to	
Other conditions Florentine Aneurism	

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op. .....

Autopsy results .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE Fuller B. Whitworth M. D. or other

Address 112 Bedford St Date signed 9 July 47.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

Within corporate limits

DR. A. JONES

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

83a

05660

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:
County ALLEGANY
City or town CUMBERLAND
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 1 mo.
Hospital, Institution, or street address where death occurred:
MEMORIAL HOSPITAL
How long in hospital or institution? 13 MINUTES

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State MARYLAND County ALLEGANY
City or town CUMBERLAND
(If outside city or town limits, write RURAL and give nearest town)
Street No. 123 Oak St.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME DAVID WESTLEY RYAN

3.(b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
MALE	WHITE	MARRIED

6.(b) Name of husband or wife MAHALA NORTHCRAFT
6.(c) If alive, give age 76 years

7. Birth date of deceased (mo., day, yr.) OCTOBER 22, 1865

8. AGE: Years	Months	Days	If less than one day
81	9	1	....hrs. ....min.

9. Birthplace MARYLAND (Town, county, and state)
10. Usual occupation RETIRED LEATHER WORKER
11. Industry or business Tannery
12. FATHER Name JOHN RYAN
13. FATHER Birthplace MARYLAND
14. MOTHER Maiden name MARGARET HARTLEY
15. MOTHER Birthplace MARYLAND
16. Informant MEMORIAL HOSPITAL
Address CUMBERLAND, MARYLAND
17. Burial (Burial, cremation, or removal. Which?) Date thereof July 26 47 (month) (day) (year)
Cemetery or crematory Camp Hill Cem.
Location Paw Paw W. Va.
18. Funeral director Louis Stein Inc
Address Cumberland
19. July 25 1947 (Date rec'd by registrar) Hunter R. Trentz M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH JULY 23 1947 at 4:28 P.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 15 1947 to July 23 1947
and that I last saw him alive on July 22 1947

Immediate cause of death	DURATION
Cerebral Vascular Accident	4 days
Due to Generalized arteriosclerosis	10 yrs.
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations ....Date of op. ....
Autopsy results ....
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide .... Date of ....
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) ....
Means of injury .... Injured at work?

23. SIGNATURE Arthur F. Jones M.D.
M. D. or other
Address 110 S. Centre St. Date signed 7-24-47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M


RECEIVED
JUL 29 1947
BUREAU V.M.

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 92d

05661

CERTIFICATE OF DEATH

Reg. Dist. No. 4

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly. M

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:

County: Allegany

City or town: Cumberland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 68 Yrs 2 Mo 20 Days

Hospital, Institution, or street address where death occurred:
166 Bedford St

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Allegany

City or town: Cumberland
(If outside city or town limits, write RURAL and give nearest town)

Street No. 166 Bedford St
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: Charles Edward Sanders

3.(b) Social Security Number: 214-05-5692

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single

6.(b) Name of husband or wife

6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): May 10 1879

8. AGE: Years	Months	Days	If less than one day
68	2	20	hrs. min.

9. Birthplace: Cumberland, Allegany Co, Maryland
(Town, county, and state)

10. Usual occupation: Stage Manager

11. Industry or business: Maryland Theatre

FATHER 12. Name: Charles J. Sanders

13. Birthplace: Cumberland, Md.

MOTHER 14. Maiden name: Margaret Vickroy

15. Birthplace: Bedford Co, Penna

16. Informant: Mrs Florence Leonard

Address: 166 Bedford St, Cumberland, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof August 2, 1947 (month) (day) (year)

Cemetery or crematory: St Peter & Paul Cemetery

Location: Cumberland, Md.

18. Funeral director: William H. Kight

Address: Cumberland, Md.

19. Aug. 1, 1947 (Date rec'd by registrar) Wilter R. Frantz M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 30 1947, at 1 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 2 1947 to July 30 1947 and that I last saw him alive on July 29 1947

Immediate cause of death: Coronary Thrombosis — DURATION

Due to: Heart Disease — Chronic Myocardial

Due to: Degeneration.

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operation: None — Date of op. None

Autopsy results: None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide — Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury — Injured at work?

23. SIGNATURE: W. F. Williams M. D. Author

Address: Cumberland Date signed: 7-30-47

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 932

05662

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:

County Allegany

City or town Cumberland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 20 yrs

Hospital, Institution, or street address where death occurred:

334 Baltimore ave

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md County Allegany

City or town Cumberland

(If outside city or town limits, write RURAL and give nearest town)

Street No. 334 Baltimore Ave

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Mrs Fannie Bell Savage

3.(b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	white	Widowed

6.(b) Name of husband or wife John C. Savage

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Nov 17, 1867

8. AGE: Years 79 | Months 8 | Days 9 | If less than one day ..... hrs. ..... min.

9. Birthplace McCoole Allegany Co. Md.
(Town, county, and state)

10. Usual occupation Housework

11. Industry or business At Home

FATHER 12. Name Silas J. McKenzie

13. Birthplace Unknown

MOTHER 14. Maiden name Sarah E. Spencer

15. Birthplace Knobley W. Va.

16. Informant Elsie L. Smith

Address 39 Cresap St - Cumberland Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof July 29 1947 (month) (day) (year)

Cemetery or crematory Hillcrest

Location Near Cumberland Md.

18. Funeral director John J. Haley

Address Cumberland Md.

19. July 28, 1947 (Date rec'd by registrar) Victor R. Krantz, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 26, 1947, at 5:45 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 8 1947 to July 26 1947 and that I last saw h[illegible] alive on July 25 1947

Immediate cause of death	DURATION
Heart failure	
Due to Arteriosclerotic heart Disease	
Due to Arteriosclerosis	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op. .....

Autopsy results .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE Estelle G. Greenawalt M.D.
M. D. or other

Address 122 Bedford St Cumberland Date signed July 28, 1947

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 94a

CERTIFICATE OF DEATH

05663

Reg. Diat. No. 4

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:

County Allegany

City or town Cumberland Md.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 10 minutes

Hospital, Institution, or street address where death occurred:
Memorial Hospital

How long in hospital or institution? 10 minutes

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Pa. County Somerset

City or town Sand Patch
(If outside city or town limits, write RURAL and give nearest town)

Street No. R. F. D. #1
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Walter C. Saylor

3.(b) Social Security Number 162-16-6868

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	married

6.(b) Name of husband or wife Cora Kendall Saylor

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) April 20, 1894

8. AGE: Years	Months	Days	If less than one day
53	2	11	..... hrs. ..... min.

9. Birthplace Glencoe Pa. Somerset County
(Town, county, and state)

10. Usual occupation Painter and Paperhanger

11. Industry or business Contractor

FATHER 12. Name Albert Saylor

13. Birthplace Sarita Somerset Co., Penna

MOTHER 14. Maiden name Sylvia Crosby

15. Birthplace Somerset Co., Penna

16. Informant Mrs. W. C. Saylor

Address Rt. #1, Sand Patch, Penna.

17. Burial (Burial, cremation, or removal. Which?) Date thereof July 4, 1947 (month) (day) (year)

Cemetery or crematory Temple Church Cem.

Location Sand Patch, Penna.

18. Funeral director H. K. Konhaus

Address Meyersdale, Penna.

19. July 1, 1947 (Date rec'd by registrar) White L. Trump, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 1 19 47, at 5.30 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....

and that I last saw him alive on dead July 1 19 47

Immediate cause of death	DURATION
Coronary occlusion	at once
Due to arteriosclerosis	
Due to	
Other conditions Angina pectoris	1 year

(Include pregnancy within 3 months of death)

Major findings of operation ..... Date of op. .....

Autopsy results .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

Deputy Medical Examiner - Allegany Co.

23. SIGNATURE H. V. Deming M.D. H. V. Deming M.D.
M. D. or other

Address Cumberland Md. Date signed 7-1-1947

Within corporate limits

DR. W.F.WMS

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 82

CERTIFICATE OF DEATH

05664

S

Reg. Dist. No. 4

1. PLACE OF DEATH:

County ALLEGANY

City or town CUMBERLAND, MARYLAND
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred: Memorial Hospital

How long in hospital or institution? 3 DAYS

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State WEST VA. County Preston

City or town TERRA ALTA
(If outside city or town limits, write RURAL and give nearest town)

Street No.
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME ROBERT A. SEAL

3. (b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
MALE	WHITE	WIDOWED

6.(b) Name of husband or wife Attie Seal

6.(c) If alive, give age 83 years

7. Birth date of deceased (mo., day, yr.) MARCH 1, 1862

8. AGE: Years	Months	Days	If less than one day
85	4	15	hrs. min.

9. Birthplace W.VA. (Town, county, and state)

10. Usual occupation Farmer

11. Industry or business

FATHER 12. Name HENRY SEAL

13. Birthplace W.VA.

MOTHER 14. Maiden name MARY - Unknown

15. Birthplace "

16. Informant Fern Guthrie

Address Terra Alta. W.Va.

17. Burial Date thereof July 18.47
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Terra Alta Cem

Location Terra Alta. W.Va.

18. Funeral director A. F. Collins

Address Terra Alta. W.Va.

19. July 16, 1947 Witter L. Franks M.D. Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH JULY 16 1947, at 9:35A M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from July 13 1947 to July 16 1947 and that I last saw h alive on July 16 1947

	DURATION
Immediate cause of death Bronchopneumonia	3 Days
Due to Bulbar Paralysis.	
Due to Cerebral Arteriosclerosis	
Other conditions Senile Infirmities	

(Include pregnancy within 3 months of death)

Major findings of operations None Date of op. None

Autopsy results None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE W. L. Williams M. D. or other

Address Cumberland Date signed 7-16-47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M


RECEIVED
JUL 22 1947
BUREAU

Within corporate limits

DR. HODGES
DR. COOPER

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

159 9 05665

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:
County ALLEGHANY
City or town CUMBERLAND, MD.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occurred:
MEMORIAL HOSPITAL
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State W. VA. County MORGAN
City or town PAW PAW
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME
SELF, BABY BOY (PREMATURE)

3.(b) Social Security Number
None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
MALE	WHITE	Single

6.(b) Name of husband or wife
6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) JULY 30, 1947

8. AGE: Years	Months	Days	If less than one day
55MINUTES			hrs. 55 min.

9. Birthplace MEMORIAL HOSPITAL Cumberland, Md.
(Town, county, and state)

10. Usual occupation

11. Industry or business

FATHER
12. Name WILLIAM SELF
13. Birthplace W. VA.

MOTHER
14. Maiden name JUDY HENRY
15. Birthplace W. VA.

16. Informant Memorial Hosp.
Address Cumberland, Md.

17. Cremation Date thereof July 30, 1947
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Memorial Hospital
Location Cumberland, Md.

18. Funeral director Same as above.
Address

19. Aug. 6 1947 Walter R. Frantz M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH JULY 30, 1947 19 at 1;25 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 20 July 1947 to 30 July 1947 and that I last saw h[illegible] alive on 30 July 1947

Immediate cause of death	DURATION
Asphyxia	
Due to Malformation of alveolar ducts	
Due to Prematurity	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operation
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE L. N. Cooper M. D. or other
Address Med. Examiner Cumberland, Md. Date signed 6 Aug 47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 131B

CERTIFICATE OF DEATH

S 05666

Reg. Dist. No. 4

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Allegany
City or town: Cumberland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 5 days.
Hospital, institution, or street address where death occurred: Memorial Hospital
How long in hospital or institution? 5 days.

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Penna. County: Bedford
City or town: Hyndman
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME James Edward Shaffer

3.(b) Social Security Number None

4. Sex: Male
5. Color or race: White
6.(a) Single, married, widowed, or divorced: Married
6.(b) Name of husband or wife: Cora Huffman Shaffer
(If not alive, give age) 71 years
7. Birth date of deceased (mo., day, yr.): Oct. 11, 1878

8. AGE: Years 68 | Months 8 | Days 29 | If less than one day: hrs. min.

9. Birthplace: Hyndman, Pa. (Town, county, and state)
10. Usual occupation: Barber
11. Industry or business: Own Business

FATHER
12. Name: Samuel Shaffer
13. Birthplace: Penna.

MOTHER
14. Maiden name: Emma Mullin
15. Birthplace: Penna.

16. Informant: Mrs. Edward Shaffer
Address: Hyndman, Pa.

17. Burial (Burial, cremation, or removal. Which?) Date thereof July 14 1947 (month) (day) (year)
Cemetery or crematory: Hyndman
Location: Hyndman, Pa.

18. Funeral director: Harvey N. Zeigler
Address: Hyndman, Pa.

19. July 14, 1947 (Date rec'd by registrar) Winter L. Fawcett, M.D. Acting Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 7/10 19 47, at 8 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 19 46, to 7-10 19 47
and that I last saw h[illegible] alive on 7-10 19 47

Immediate cause of death	DURATION
Chronic Glomerular Nephritis	2yrs.
Due to	
Due to	
Other conditions: Emphysema	11 months

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide. Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE John A Tapper M.D. M. D. or other
Address Hyndman Pa. Date signed 7/13/47


RECEIVED
JUL 22 1947
BUREAU

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 97

CERTIFICATE OF DEATH

05687

Reg. Dist. No. 4

1. PLACE OF DEATH:

County: Allegany

City or town: Cumberland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 87 Years 7 mo 16 Days

Hospital, Institution, or street address where death occurred:
205 Piedmont Ave

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Allegany

City or town: Cumberland
(If outside city or town limits, write RURAL and give nearest town)

Street No. 205 Piedmont Ave
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: Sallie Shinholt

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widow

6.(b) Name of husband or wife: John W. Shinholt — 6.(c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr.): December 11 1859

8. AGE: Years	Months	Days	If less than one day
87	7	16	____ hrs. ____ min.

9. Birthplace: Cumberland, Allegany Co, Maryland
(Town, county, and state)

10. Usual occupation: House

11. Industry or business: "

FATHER
12. Name: Lewis Shinholt
13. Birthplace: Germany

MOTHER
14. Maiden name: Nancy McCandliss
15. Birthplace: Sharpsburg, Md.

16. Informant: Miss Hazel Shinholt
Address: 205 Piedmont Ave, Cumberland, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 7/29/47 (month) (day) (year)

Cemetery or crematory: Rose Hill Cemetery

Location: Cumberland, Md.

18. Funeral director: William H. Kight

Address: Cumberland, Md.

19. July 29 1947 (Date rec'd by registrar) Wintes R. Stauffer M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 27 1947 at 6-45 A.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from July 12 1947 to July 27 1947 and that I last saw h[illegible] alive on July 27 1947

	DURATION
Immediate cause of death: Arteriosclerosis	?
Due to: Chronic Passive Congestion of Lungs	10 days
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations: ____ Date of op. ____

Autopsy results: ____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ____ Date of ____

Where did injury occur? ____ (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) ____

Means of injury ____ Injured at work?

23. SIGNATURE: W. R. Hodges, M. D.

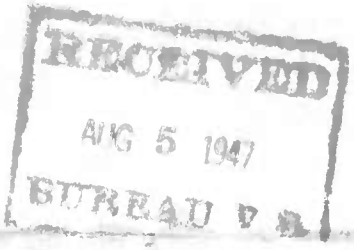
Address: Cumberland, Md. M. D. or other

Date signed: 7/28/47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M


RECEIVED
AUG 5 1947
BUREAU P R

Within corporate limits

DR TOPPER

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

46 B 5

05668

Reg. Dist. No. 4

M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

I

VS A15 9-45-15M

1. PLACE OF DEATH:
County ALLEGHENY
City or town CUMBERLAND, MD.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 2DAYS
Hospital, institution, or street address where death occurred:
MEMORIAL HOSPITAL
How long in hospital or institution? 2 DAYS

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State PENNSYLVANIA County BEDFORD
City or town MANN'S CHOICE
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME MRS. CARRIE SIDES

3.(b) Social Security Number None

4. Sex	5. Color or race	8.(a) Single, married, widowed, or divorced
FEMALE	WHITE	MARRIED

6.(b) Name of husband or wife JACOB SIDES
6.(c) If alive, give age 71 years

7. Birth date of deceased (mo., day, yr.) JULY 17, 1872

8. AGE: Years	Months	Days	If less than one day
75	0	2	hrs. min.

9. Birthplace PENNSYLVANIA (Town, county, and state)
10. Usual occupation HOUSEWIFE
11. Industry or business

FATHER
12. Name ALBERT CORLEY
13. Birthplace PA.

MOTHER
14. Maiden name RACHAEL COUGHENOUR
15. Birthplace PA.

16. Informant Mr. Jacob Sides
Address Mann's Choice, Pa.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 7/22/47 (month) (day) (year)
Cemetery or crematory Dry Ridge
Location Mann's Choice R.D.
18. Funeral director Harvey H. Zeigler
Address Hyndman, Pa.

19. July 21, 1947 (Date rec'd by registrar) Pickett S. Frantz Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH JULY 19, 1947 19 12:15 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan. 19 44, to July 19, 19 47
and that I last saw h alive on July 18 19 47

Immediate cause of death	DURATION
Carcinoma of liver	3 yrs.
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE John A Topper M. D. or other
Address Hyndman Pa Date signed 7/21/47


RECEIVED
JUL 29 1947

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

159

05669

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:

County: Allegany

City or town: Cumberland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 6 hrs.

Hospital, institution, or street address where death occurred: Allegany Hospital

How long in hospital or institution? 6 hrs.

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Allegany

City or town: Cumberland

(If outside city or town limits, write RURAL and give nearest town)

Street No. 475 Grand Ave.

(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: Baby Boy Slaton

3.(b) Social Security Number: None

4. Sex: Male

5. Color or race: White

6.(a) Single, married, widowed, or divorced: Single

6.(b) Name of husband or wife:

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): July 22 1947

8. AGE: Years | Months | Days | If less than one day: 12 hrs. 3 min.

9. Birthplace: Cumberland Md. (Town, county, and state)

10. Usual occupation: none

11. Industry or business:

FATHER — 12. Name: Wm Slaton

13. Birthplace: Elkins W. Va.

MOTHER — 14. Maiden name: Geraldine Portmess

15. Birthplace: Md.

16. Informant: Wm Slaton

Address: Cumberland Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof July 24 47 (month) (day) (year)

Cemetery or crematory: Rose Hill Cem.

Location: Cumberland

18. Funeral director: Louis Stein, Inc.

Address: Cumberland

19. July 24, 1947 (Date rec'd by registrar) Winters L. Fauntz M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 23 1947 at 12:50 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 22 1947 to July 23 1947 and that I last saw him alive on July 22 1947

	DURATION
Immediate cause of death: Atelectasis	
Due to: Prematurity	10hrs
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: A. T. Lee Jr. M.D. M. D. or other

Address: 108½ Md. Ave. Date signed: 7/24/47

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

Wm. married 11-[illegible] Dill. Jones

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

1318

05670

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:

County Allegany

City or town Cumberland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 64 years

Hospital, institution, or street address where death occurred:
Memorial Hospital

How long in hospital or institution? 1½ day

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County Allegany

City or town Cumberland
(If outside city or town limits, write RURAL and give nearest town)

Street No. [redacted] 461 Columbia St.
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME

Mr. William Smith

3.(b) Social Security Number

None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single

6.(b) Name of husband or wife

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) March 13, 1883

8. AGE: Years 64 | Months 3 | Days 26 | If less than one day ..... hrs. ..... min.

9. Birthplace Cumberland, Maryland
(Town, county and state)

10. Usual occupation Unemployed

11. Industry or business

FATHER
12. Name John C. Smith
13. Birthplace Germany

MOTHER
14. Maiden name Wilhelmina Heubner
15. Birthplace Germany

16. Informant Sylvan Retreat
Address Cumberland, Md.

17. Burial
(Burial, cremation, or removal. Which?)
Date thereof July 11, 1947
(month) (day) (year)

Cemetery or crematory Greenmount Cemetery

Location Cumberland, Md.

18. Funeral director John J. Hafer

Address Cumberland, Md.

19. July 11, 1947 Winter R. Frantz, M.D. Registrar
(Date rec'd by registrar) dating

MEDICAL CERTIFICATION

20. DATE OF DEATH July 9, 1947, at 3:00 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec 1946 to July 9 1947 and that I last saw him alive on July 8 1947

Immediate cause of death	DURATION
Uremic poisoning	8 days
Due to Chronic nephritis	2 yrs
Due to Chronic urinary retention	2 yrs
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operation ..... Date of op. .....

Autopsy results .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE Arthur F. Jones M.D.
M. D. or other

Address 110 S. Centre St. Date signed 7-9-47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

05671

169

Reg. Diat. No. 14

1. PLACE OF DEATH:

County: Allegany

City or town: Near Ellerslie, rural
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:
Found on Baltimore & Ohio R. R. Co. tracks

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Md. County: Howard

City or town: Ellicott City
(If outside city or town limits, write RURAL and give nearest town)

Street No.: St. Paul Street
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: William Henry Patrick Snowden

3.(b) Social Security Number: Unknown

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	colored	single

6.(b) Name of husband or wife

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): March 17, 1904

8. AGE: Years	Months	Days	If less than one day
43	3	18	..... hrs. ..... min.

8. Birthplace: Ellicott City, Howard County, Maryland
(Town, county, and state)

10. Usual occupation: Laborer

11. Industry or business: Continental Milling Co.

FATHER
12. Name: Stephen Snowden
13. Birthplace: Unknown

MOTHER
14. Maiden name: Emma Dorsey
15. Birthplace: Ellicott City, Maryland.

16. Informant: Mrs. Emma Snowden
Address: Ellicott City, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof July 8, 1947 (month) (day) (year)

Cemetery or crematory: Western Star Cem.

Location: Catonsville, Md.

18. Funeral director: Clinton Easton

Address: Ellicott City, Md.

19. July 8, 1947 (Date rec'd by registrar) J Lloyd Wolfe Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 5 1947 at about 5 A. M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from ..... 19..... to ..... 19.....

and that I last saw him alive on ..... 19..... Dead July 5 1947

Immediate cause of death	DURATION
Exsanguination, body dismembered & crushed skull	at once
Due to: Falling under B.& O R.Ry. train	
Due to:	
Other conditions: (trespasser)	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: accident Date of 7.5.47

Where did injury occur? Ellerslie (City or town) Allegany (County) Md. (State)

Injured at home, farm, industry, public place (where?) B.&.O R.Ry

Means of injury: Fell beneath wheels of train. (While at work?)

Deputy Medical Examiner - Allegany Co.

23. SIGNATURE: H. V. Deming M.D. M. D. or other

Address: Cumberland, Md. Date signed 7.6.47

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

05672

932

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:

County: Allegany

City or town: Cumberland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:
Allegany County Infirmary

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Allegany

City or town: Cumberland
(If outside city or town limits, write RURAL and give nearest town)

Street No.: 55 Boone St.
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME: Amnie E. Sommerkamp

3. (b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widowed

6.(b) Name of husband or wife: Charles Sommerkamp

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): March 10, 1870

8. AGE: Years	Months	Days	If less than one day
77	4	13	hrs. min.

9. Birthplace: Keyser, W. Va.
(Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business

FATHER
12. Name: John Cain
13. Birthplace: W. Va.

MOTHER
14. Maiden name: Chapman
15. Birthplace: Va.

16. Informant: Mrs. Kathryn Wilson
Address: 55 Boone St. Cumberland, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: July 25, 1947 (month) (day) (year)
Cemetery or crematory: Queens Point Cem.
Location: Keyser, W. Va.

18. Funeral director: Charles L. George
Address: Cumberland, Md.

19. July 25 1947 (Date rec'd by registrar) Winter R. Trantz, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 23, 1947 at 4A. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec 1946 to July 23 1947
and that I last saw her alive on July 22 1947

	DURATION
Immediate cause of death: Myocardial Failure	6 days
Due to: Chronic Myocarditis	8 yrs.
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Arthur F. Jones M.D. M. D. or other

Address: 110 S. Centre St. Date signed: 7-24-47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

Outside of City Limits

Schindler

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 9 056734

1. PLACE OF DEATH:

County: Allegany

City or town: Rural - Cumberland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred:

Rt. 3, Cumberland, Md

How long in hospital or Institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md County: Allegany

City or town: Cumberland

(If outside city or town limits, write RURAL and give nearest town)

Street No. Rt. 3 - Valley Road

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Georgetta Leslie Spicer

3.(b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	Single

6.(b) Name of husband or wife

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): June 4, 1947

8. AGE:

Years	Months	Days	If less than one day
0	1	25	..... hrs. ..... min.

9. Birthplace: Cumberland, Allegany, Md.

(Town, county, and state)

10. Usual occupation: Infant.

11. Industry or business

FATHER

12. Name: George Spicer

13. Birthplace: Rawlesburg, W. Va.

MOTHER

14. Maiden name: Hazel Frantz

15. Birthplace: Cumberland, Md.

16. Informant: George Spicer

Address: Rt. 3, Cumberland, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof July 31, 1947 (month) (day) (year)

Cemetery or crematory: Sts. Peter & Paul's Cemetery

Location: Cumberland, Md.

18. Funeral director: John F. Wagner

Address: Cumberland, Md.

19. July 31, 1947 (Date rec'd by registrar) Winter R. Frantz, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 29, 1947, at 4:00 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 10 1947, to July 29 1947 and that I last saw h.e alive on July 28 1947.

Immediate cause of death: Whooping Cough — DURATION: 3 weeks.

Due to:

Due to:

Other conditions:

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: injured at work?

23. SIGNATURE: By M. Schindler Jr. M. D. or other

Address: 41 Fremont Date signed: July 31, 1947

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. (Incorrect age is especially important. Physicians: please write the causes of death clearly and legibly.)

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

Within corporate limits

DR. ENFIELD

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

05674

CERTIFICATE OF DEATH

46d S

Reg. Dist. No. 4

1. PLACE OF DEATH:
County ALLEGANY
City or town CUMBERLAND, MD.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
MEMORIAL HOSPITAL
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State WEST VIRGINIA County MINERAL
City or town KEYSER
(If outside city or town limits, write RURAL and give nearest town)
Street No. 264 ST. CLOUD STREET
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME
MR. IRA THOMAS

3.(b) Social Security Number
None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
MALE	WHITE	MARRIED

6.(b) Name of husband or wife CARRIE (JAMES) THOMAS
6.(c) If alive, give age 65 years

7. Birth date of deceased (mo., day, yr.) MAY 26, 1872

8. AGE: Years 75 Months Days If less than one day hrs. min.

9. Birthplace NORTH CAROLINA
(Town, county, and state)

10. Usual occupation RETIRED

11. Industry or business

FATHER
12. Name JOHN C. THOMAS
13. Birthplace NORTH CAROLINA

MOTHER
14. Maiden name ADALINE PAYNE
15. Birthplace NORTH CAROLINA

16. Informant J. W. Green
Address Keyser W. Va.

17. Burial (Burial, cremation, or removal. Which?) Date thereof July 14 47 (month) (day) (year)
Cemetery or crematory Queens Point
Location Keyser W. Va.

18. Funeral director B. N. Markwood
Address Keyser W. Va.

19. July 14, 1947 (Date rec'd by registrar) Whiteford Fraley, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH JULY 12, 1947 5:15 A.M. (Month) (Day) (Year) (Hour) M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 27 1947 to July 12 1947 and that I last saw h alive on July 12 1947

DURATION

Immediate cause of death Cardiac Dilatation

Due to Post Apoplectic Arteriosclerosis

Due to Senility

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations Carcinoma of Rectum Date of op

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE L. C. Engelhard M. D. or other

Address Cumberland Date signed 7/12/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

Within corporate limits

DR. F. WILLIAMS

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

61 S 05675

Reg. Dist. No. 4

1. PLACE OF DEATH:
County ALLEGHANY
City or town CUMBERLAND, MD.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
MEMORIAL HOSPITAL
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State W.VA. County HAMPSHIRE
City or town ROMNEY
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: MISS ANITA C. TRUMAN

3.(b) Social Security Number: X

4. Sex: FEMALE
5. Color or race: WHITE
6.(a) Single, married, widowed, or divorced: Single
6.(b) Name of husband or wife: X
6.(c) If alive, give age: X years
7. Birth date of deceased (mo., day, yr.): Aug 3- 1928
8. AGE: Years: 18 YEARS; Months: 11; Days: 26; If less than one day: hrs. min.
9. Birthplace: WEST VIRGINIA (Town, county, and state)
10. Usual occupation: WAITRESS
11. Industry or business
FATHER 12. Name: EVERETT TRUMAN
FATHER 13. Birthplace: KY.
MOTHER 14. Maiden name: MARY CARVEY
MOTHER 15. Birthplace: W.VA.
16. Informant: Mrs Mary Truman
Address: Romney W.va
17. Burial (Burial, cremation, or removal. Which?) Date thereof July 31 1947. (month) (day) (year)
Cemetery or crematory: Fort Ashby
Location: Fort Ashby, W.Va
18. Funeral director: A.C. Ruckman No 480
Address: Romney, W.va.
19. July 29, 1947 (Date rec'd by registrar) Winter R. Frantz, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: JULY 29, 1947, 12:06 A.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from July 28 1947 to July 29 1947
and that I last saw h alive on July 29 1947

	DURATION
Immediate cause of death	
Diabetes Mellitus	one day
Due to	
Coma	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: none
Date of op. none
Autopsy results: none
PHYSICIAN: Please underline the cause to which death should be charged statistically.

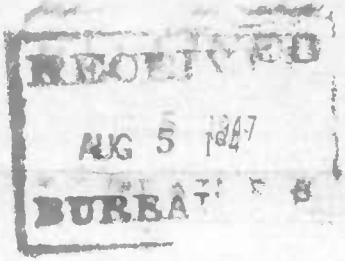
22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE: W. F. Williams M. D. or other
Address Cumberland Date signed 7-29-47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M


RECEIVED
AUG 5 1947
BUREAU

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

05676

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:
County: Allegany
City or town: Cumberland Md.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 45 minutes
Hospital, institution, or street address where death occurred:
Allegany Hospital
How long in hospital or institution? 45 minutes

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Allegany
City or town: Cumberland
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 631 Henderson Ave
(If rural, give LOCATION)
2.(a) If veteran, name war: World War 2

3.(a) FULL NAME: Floyd Edward Vanderhout

3.(b) Social Security Number: 216-22-5747

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	single

6.(b) Name of husband or wife:
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): July 24 1927

8. AGE: Years	Months	Days	If less than one day
20	0	3	hrs. min.

9. Birthplace: Cumberland Md.
(Town, county, and state)
10. Usual occupation: Bottling Plant
11. Industry or business: Brewery
FATHER 12. Name: Adrianus H Vanderhout
13. Birthplace: Amsterdam Holland
MOTHER 14. Maiden name: Myra C Rose
15. Birthplace: Bedford Pa.
16. Informant: Adrianus H Vanderhout
Address: Cumberland
17. Buried (Burial, cremation, or removal. Which?) Date thereof: July 29 47 (month) (day) (year)
Cemetery or crematory: St Peter & Paul's Cem.
Location: Cumberland
18. Funeral director: Louis Stein Inc
Address: Cumberland
19. July 28, 1947 (Date rec'd by registrar) Walter R. Frantz, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 27 19 47 at 4.15 AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ... 19... to ... 19...
and that I last saw him alive Dead July 27 19 47

Immediate cause of death: Shock — DURATION: 1 hour & 45 min.
Fracture of the skull, intra-cranial hemorrhage
also fracture of lower maxillary
fracture of both femurs, compound
comminuted fracture right tibia &
fibulae, due to auto. accident.
Other conditions: Puncture wound left buttock.
(Include pregnancy within 3 months of death)

Major findings of operations: ... Date of op. ...
Autopsy results: ...
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Accident Date of: 7-27-47
Where did injury occur? Barrlesville (City or town) Allegany (County) Md. (State)
Injured at home, farm, industry, public place (where?): Route # 36 Junction, Wellersburg & Mt. Savage Road
Means of injury: Auto. hit rock Injured at work? no

Deputy Medical Examiner - Allegany Co.

23. SIGNATURE: H.V.Deming M.D. H.V.Deming M.D.
M. D. or other
Address: Cumberland, Md Date signed: 7-28-47

PLEASE WRITE PLAINLY, WITH NON-FADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

94a

CERTIFICATE OF DEATH

B

05677

Reg. Diat. No. 9

1. PLACE OF DEATH:

County: Allegany

City or town: Frostburg Md.

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 1 day

Hospital, Institution, or street address where death occurred: Miners Hospital

How long in hospital or institution? 2 hours

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Iowa County: Des Moines

City or town: Burlington

(If outside city or town limits, write RURAL and give nearest town)

Street No. 615 Summer St

(If rural, give LOCATION)

2.(a) If veteran, name war: World War I ✓

3.(a) FULL NAME: Alvin Joslin Walters

3.(b) Social Security Number: 707-05-7101

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Margaret Roberts Walters

6.(c) If alive, give age: 47 years

7. Birth date of deceased (mo., day, yr.): September 12, 1894

8. AGE: Years	Months	Days	If less than one day
52	10	16	..... hrs. ..... min.

9. Birthplace: Christiansburg Virginia (Town, county and state)

10. Usual occupation: Retired

11. Industry or business

FATHER — 12. Name: John William Walters

FATHER — 13. Birthplace: Montgomery Co. Va

MOTHER — 14. Maiden name: Lola Madeira Smith

MOTHER — 15. Birthplace: Montgomery Co, Va

16. Informant: Mrs A.J. Walters

Address: 615 Summer St, Burlington, Iowa

17. Burial (Burial, cremation, or removal. Which?) Date thereof: August 1, 1947 (month) (day) (year)

Cemetery or crematory: Memorial Park Cem.

Location: Burlington Iowa

18. Funeral director: L.E. Durst

Address: Frostburg, Md.

19. 7-28-47 (Date rec'd by registrar) Mrs Hadley N. Rice Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 28 1947, at 5:30 P.M. EST

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 28 1947 to July 28 1947 and that I last saw him alive on July 28 1947

Immediate cause of death	DURATION
Coronary occlusion	2½ hrs
Due to: Coronary Heart disease	8 years
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results: .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of Injury ..... Injured at work?

23. SIGNATURE: Hilda Rose Walters M.D. M. D. or other

Address: Frostburg Md Date signed: 7/28/47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The omission of any item is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

05678

Reg. Diat. No. 4

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:

County Allegany

City or town Cumberland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 12 yrs.

Hospital, institution, or street address where death occurred: Allegany Hospital

How long in hospital or institution? 3 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Allegany

City or town Cumberland

(If outside city or town limits, write RURAL and give nearest town)

Street No. 326 Everett Ave.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Frank Louis Werner

3.(b) Social Security Number 214-12-3203

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife Julia Walsh.

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) November 15 1900

8. AGE: Years	Months	Days	If less than one day
46	7	17	..... hrs. ..... min.

9. Birthplace Clifton Forge Va. (Town, county, and state)

10. Usual occupation Telegraph Editor.

11. Industry or business Newspaper.

FATHER 12. Name Joseph Werner

13. Birthplace Va.

MOTHER 14. Maiden name Margaret Nolan

15. Birthplace Va.

16. Informant Wm C Walsh.

Address Cumberland.

17. Burial (Burial, cremation, or removal. Which?) Date thereof July 4 47 (month) (day) (year)

Cemetery or crematory St Patricks Cem.

Location Cumberland Md.

18. Funeral director Louis Stein Inc

Address Cumberland.

19. July 3 1947 (Date rec'd by registrar) Wesley L. Frank, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 2 1947, at 6.45 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 1947, to July 2 1947 and that I last saw him alive on July 2 1947

Immediate cause of death	DURATION
(a) Acute Gangrenous Appendicitis	4 days
Due to (b)	
Due to (c)	
Other conditions Coronary Occlusion Myocarditis Thrombosis	

(Include pregnancy within 3 months of death)

Major findings of operation Acute gangrenous appendicitis Date of op. 6-29-47

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE Jos. F. Johnson Jr. M.D. M. D. or other

Address Cumberland Md Date signed 7-3-47

Within corporate limits

DR. R. WILLIAMS

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

93d

05679

Reg. Diat. No. 4

1454

M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

I

VS A15 9-45-15M

1. PLACE OF DEATH:

County ALLEGANY

City or town CUMBERLAND
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 5 years

Hospital, institution, or street address where death occurred:
MEMORIAL HOSPITAL

How long in hospital or institution? 39 DAYS

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State MARYLAND County ALLEGANY

City or town CUMBERLAND
(If outside city or town limits, write RURAL and give nearest town)

Street No. 17 DEXTER PLACE
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME

PAUL WHITE

3.(b) Social Security Number

232-05-5499

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
MALE	WHITE	SEPARATED

6.(b) Name of husband or wife AUDREY LEE

6.(c) If alive, give age 32 years

7. Birth date of deceased (mo., day, yr.) JULY 17, 1901

8. AGE: Years	Months	Days	If less than one day
45	11	21	...hrs. ...min.

9. Birthplace WEST VIRGINIA
(Town, county, and state)

10. Usual occupation TRUCK DRIVER

11. Industry or business

FATHER

12. Name DANIEL WHITE

13. Birthplace WEST VIRGINIA

MOTHER

14. Maiden name SARAH PHILLIPS

15. Birthplace WEST VIRGINIA

16. Informant MEMORIAL HOSPITAL

Address CUMBERLAND, MARYLAND

17. Burial (Burial, cremation, or removal. Which?) Date thereof 7/11/47 (month) (day) (year)

Cemetery or crematory Beverly Hill Cem

Location Morgantown W Va

18. Funeral director Pelham & Wright

Address Cumberland Md

19. July 9 1947 (Date rec'd by registrar) Whitney L. Frauenheim M.D. Acting Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH JULY 8, 1947 at 7:25 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 5, 47 19... to July 8, 47 19...

and that I last saw h...alive on 7/8/47 19...

Immediate cause of death Arterio Sclerosis C.V.D. DURATION 5 yrs

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations ...Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ... Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of Injury ... Injured at work?

23. SIGNATURE D. M. Pelham M.D. M. D. or other

Address ... Date signed 7/9/47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

168

05680

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:

County Allegany

City or town Cumberland Md. (rural)

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Allegany Hospital

How long in hospital or institution? died before being admitted

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County Allegany

City or town Rural) Cumberland Md.

(If outside city or town limits, write RURAL and give nearest town)

Street No. R.F.D. #4 Christy Road

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME Junior Clinton Wills

3. (b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	single

6.(b) Name of husband or wife

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) January 11, 1946

8. AGE: Years 1 Months 6 Days 9 If less than one day ..... hrs. ..... min.

9. Birthplace Cumberland, Md (Town, county, and state)

10. Usual occupation None

11. Industry or business

FATHER 12. Name Mervin C. Wills

13. Birthplace Maryland

MOTHER 14. Maiden name Nancy Joretta Divelbliss

15. Birthplace Maryland

16. Informant Mrs. Mervin C. Wills

Address Rt. #4, Cumberland, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof July 23, 1947 (month) (day) (year)

Cemetery or crematory Allegany Cem

Location Ft. Hill, Md.

18. Funeral director Louis Stein, Inc.

Address Cumberland, Md.

19. July 23, 1947 (Date rec'd by registrar) Winter L. Frantz, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 20 1947 at 8.20 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....

and that I last saw him alive on Dead July 20 1947

Immediate cause of death	DURATION
Intracranial hemorrhage & Intraabdominal hemorrhage	a few days
Due to External & internal injuries	
Due to numerous contusions & abrasions	
Other conditions Fracture of the clavicle	

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op. .....

Autopsy results as above

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide homicide Date of 7-19-20/47

Where did injury occur? rural) Cumberland (City or town) Allegany (County) Md. (State)

Injured at home, farm, industry, public place (where?) home

Means of injury Whippings & falls Injured at work? no

Deputy Medical Examiner Allegany Co.

23. SIGNATURE H.V. Deming M.D. H.V. Deming M.D. M. D. or other

Address Cumberland, Md Date signed 7-23-47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M


RECEIVED
JUL 29 1947
BUREAU V.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

83a

CERTIFICATE OF DEATH

Reg. Dist. No. 05681 9

1. PLACE OF DEATH:

County Allegany

City or town Frostburg

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 5 hrs.

Hospital, institution, or street address where death occurred:

219 Mayble St

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County Allegany

City or town Frostburg (If outside city or town limits, write RURAL and give nearest town)

Street No. 219 Mayble St. (If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME Harry Edmund Wilson

3. (b) Social Security Number 712-14-1610

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife Hazel Strickmaker

6.(c) If alive, give age 40 years

7. Birth date of deceased (mo., day, yr.) Jan. 1st. 1902

8. AGE:

Years	Months	Days	If less than one day
45	6	19	hrs. min.

9. Birthplace Shaft, Allegany, Md. (Town, county, and state)

10. Usual occupation Garage Keeper

11. Industry or business Frostburg Auto Co

FATHER 12. Name Harry F. Wilson

13. Birthplace Mt Savage, Md.

MOTHER 14. Maiden name Margaret Amy Dawson

15. Birthplace Cumberland, Md.

16. Informant Earl F. Wilson

Address 219 Maple St. Frostburg Md

17. Burial (Burial, cremation, or removal? Which?) Date thereof 7-23-1947 (month) (day) (year)

Cemetery or crematory Allegany

Location Frostburg, Md.

18. Funeral director Isaac Baker

Address Frostburg, Md.

19. 7-22 1947 (Date rec'd by registrar) Jas. Harvey H. Roe Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 20 1947 at 8:43 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 1947 to July 20 1947 and that I last saw h alive on July 20 1947

Immediate cause of death	DURATION
Cerebral Hemorrhage	2½ hrs
Due to Malignant Hypertension	6 mo
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE J. M. McLane Jr. M.D. M. D. or other

Address Frostburg Md Date signed July 21 1947

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

05682

Reg. Dist. No. 4

DR. A. JONES 1454 1579

1. PLACE OF DEATH:

County: ALLEGANY

City or town: CUMBERLAND
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 5 Days

Hospital, Institution, or street address where death occurred:
MEMORIAL HOSPITAL

How long in hospital or institution? 5 DAYS

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: W. VA County: Hampshire

City or town: VANDERLIP
(If outside city or town limits, write RURAL and give nearest town)

Street No.
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: ROBERT LARRY WOLFORD

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
MALE	WHITE	SINGLE

6.(b) Name of husband or wife

6.(c) If alive, give age ... years

7. Birth date of deceased (mo., day, yr.): June 10, 1947

8. AGE: Years | Months: 1 | Days: 5 | If less than one day: ... hrs. ... min.

9. Birthplace: W. VA (Town, county, and state)

10. Usual occupation

11. Industry or business

FATHER
12. Name: Charles Wolford
13. Birthplace: West Virginia

MOTHER
14. Maiden name: LENA WOLFORD
15. Birthplace: W. VA

16. Informant: Memorial Hospital
Address: Cumberland, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 7/16/47 (month) (day) (year)

Cemetery or crematory: Charles Wolford Family Cemetery

Location: Vanderlip, W. Va.

18. Funeral director: Ralph Guthrie
Address: Romney, W. Va.

19. July 16, 1947 (Date rec'd by registrar) Walter R. Beauty, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: JULY 15 1947 at 8:40AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 10 1947, to July 15 1947 and that I last saw him alive on July 15 1947

	DURATION
Immediate cause of death: Operative Shock	35 min
Due to: Operation for bowel strangulation	7-15-47
Due to: Congenital anomaly stenosis	Two.
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations ... Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ... Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury ... Injured at work?

23. SIGNATURE: Arthur F. Jones M.D. M. D. or other

Address: 110 S. Centre St. Date signed: 7-16-47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Be sure correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

186a

CERTIFICATE OF DEATH

Reg. Dist. No. 05683 4

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:

County: Allegany

City or town: Cumberland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Memorial Hospital

How long in hospital or institution? 14 weeks

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Allegany

City or town: Frostburg

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: RUTH E. YATES

3.(b) Social Security Number: none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Single

6.(b) Name of husband or wife

6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): March 20, 1868

8. AGE: Years	Months	Days	If less than one day
79	4	11	hrs. min.

9. Birthplace: Morantown, Allegany, Maryland (Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business

FATHER 12. Name: Benjamin Yates

FATHER 13. Birthplace: Wales

MOTHER 14. Maiden name: unknown

MOTHER 15. Birthplace

16. Informant: Mrs. Albert Lewis

Address: Frostburg, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof August 3 '47 (month) (day) (year)

Cemetery or crematory: Allegany Cemetery

Location: Frostburg, Md.

18. Funeral director: J. R. Durst,

Address: Frostburg, Md.

19 Aug. 1, 1947 (Date rec'd by registrar) White R. Beauty, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 31 1947, at 11.02 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 9 1947 to July 31 1947 and that I last saw h[illegible] alive on July 31 1947

Immediate cause of death	DURATION
Myocardial failure	7.
with	
Due to Intramed bilateral hypostatic pneumonia	3 days.
Due to	
Other conditions Fracture, Hip. right.	

May 9, 1947 (Include pregnancy within 3 months of death)

Major findings of operation Reduction fract hip. Date of op May 10, 1947

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Accident Date of 5/9/47

Where did injury occur? (City or town) alley Co. (County) Md (State)

Injured at home, farm, industry, public place (where?) (8/27/47 a.s.)

Means of injury Fell down stairs Injured at work?

23. SIGNATURE Wyhe M Faw Jr M. D. M. D. or other

Address 5 Washington St. Date signed 1 Aug. 1947

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

05684

Reg. Dist. No. 4

DR. ELIASON Grove 161a

1. PLACE OF DEATH:
County ALLEGHANY
City or town CUMBERLAND, MD.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 14 days
Hospital, institution, or street address where death occurred:
MEMORIAL HOSPITAL
How long in hospital or institution? 14 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State MARYLAND County ALLEGHANY
City or town CUMBERLAND
(If outside city or town limits, write RURAL and give nearest town)
Street No. 1038 MYRTLE STREET
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME
YOUNG, BABY GIRL

3.(b) Social Security Number
None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
FEMALE	WHITE	Single

6.(b) Name of husband or wife
6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) JULY 12, 1947

8. AGE: Years	Months	Days	If less than one day
14 DAYS		14	hrs. min.

9. Birthplace MARYLAND, Cumberland, Alleg. Co.
(Town, county, and state)

10. Usual occupation

11. Industry or business

FATHER
12. Name YOUNG, HARRY
13. Birthplace MD.

MOTHER
14. Maiden name ROBERTSON, L. LAVONNE
15. Birthplace PA.

16. Informant Memorial Hospital
Address Cumberland, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 7/28/47 (month) (day) (year)
Cemetery or crematory Hill Crest Cemetery
Location Cumberland, Md.

18. Funeral director William H. Kight
Address Cumberland, Md.

19. July 28, 1947 (Date rec'd by registrar) Winter R. Trautz, M Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 26 1947, at 1 45 A. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 12 1947 to July 26 1947 and that I last saw her alive on July 26 1947

Immediate cause of death	DURATION
Collapsed Lung	14d.
Due to Pneumothorax	14d.
Due to 1610	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE D. D. Grove, M.D. (with)
Address D. Cumberland, Md. M. D. or coroner
Date signed 7/28/47

VS A15 9-45-15M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.